

Medicare Prescription Drug Benefit Manual

Chapter 3 - Eligibility, Enrollment and Disenrollment

Update: **August 19, 2009**

This guidance update is effective for contract year 2010. All enrollments with an effective date on or after January 1, 2010, must be processed in accordance with the revised guidance requirements, including new model enrollment forms and notices provided. Organizations may, at their option, implement any aspect of this guidance (e.g. new model forms/notices) prior to the required implementation date.

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Instructions provided in this guidance apply to Medicare Prescription Drug Plans (PDPs) and to 1876 Cost plans offering an optional supplemental Part D benefit. Guidance for eligibility, enrollment and disenrollment procedures for Medicare Advantage (MA) plans is established in the MA Enrollment and Disenrollment Guidance (Chapter 2 of the Medicare Managed Care Manual).

10 - Eligibility and Enrollment in a Part D Plan

42 CFR 423.30

In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and/or Part B as of the effective date of coverage under the plan; and
2. The individual permanently resides in the service area of a PDP.

An individual who is living abroad or is incarcerated is not eligible for Part D as he or she cannot meet the requirement of permanently residing in the service area of a Part D plan.

A PDP sponsor may not impose any additional eligibility requirements as a condition of enrollment other than those permitted by CMS.

For those not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B or those not eligible for Part D during first Medicare initial enrollment period for Part D that occurred from November 15, 2005, through May 15, 2006, their initial enrollment period is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D. For individuals whose Medicare entitlement determination is made retroactively, Part D eligibility begins with the month the individual receives the notice of the Medicare entitlement determination, as described in §20.1.

Individuals may request enrollment in a Part D plan only during an enrollment period, as described in §20. A PDP sponsor cannot deny a valid enrollment request from any Part D eligible individual residing in its service area, except as provided in this guidance. Individuals enrolling in a Medicare Advantage Prescription Drug (MA-PD) plan are subject to the procedures provided in the MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2).

Individuals in a cost-based HMO/CMP have the option to enroll in a standalone PDP, regardless of whether Part D is offered as an optional supplemental benefit by the cost plan. Individuals enrolling in a Part D plan that is offered as an optional supplemental benefit in a Cost-based HMO/CMP plan must do so according to the requirements for

enrollment in a PDP contained in this guidance. Such an individual must be a cost plan member to enroll in the cost plan's optional supplemental Part D benefit.

A PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. However, if an individual enrolls in a PDP and continues to enroll in an employer/union plan for which the retiree drug subsidy (RDS) is claimed, the retiree drug subsidy will terminate, at which point coordination of benefits (COB) rules will apply.

A Part D eligible individual may not be enrolled in more than one Part D plan at the same time. A Part D eligible individual may not be simultaneously enrolled in a PDP and a Medicare Advantage (MA) plan except for a MA Private Fee-For-Service (PFFS) plan that does not offer the Part D benefit, a Medicare Medical Savings Account (MSA), or unless otherwise provided under CMS waiver authority.

The PFFS exception is applied at the plan level (i.e. *the PBP or "plan benefit package" level*). An individual enrolled in an MA PFFS plan that does not offer Part D may enroll in a stand-alone PDP, even if the same MA organization offers other plans (including PFFS plans) that include a prescription drug benefit.

10.1 - Entitlement to Medicare Parts A and/or B

To be eligible for Part D and to enroll in a PDP, an individual must be entitled to Medicare Part A or enrolled in Part B as of the effective date of coverage under the PDP. §30.2 provides information on verification of Medicare entitlement.

10.2 - Place of Permanent Residence

An individual is eligible for Part D and able to enroll in a PDP if he/she permanently resides in the service area (region) of the PDP. A temporary stay in the PDP's service area does not enable the individual to enroll. An individual who is living abroad or is incarcerated does not meet the requirement of permanently residing in the service area of a Part D plan (even if the correctional facility is located within the plan service area).

Individuals who are confined in state hospitals, IMDs (Institutions for Mental Disease), psychiatric hospitals, or the psychiatric unit of a hospital are not considered to be "incarcerated" as CMS defines that term, and are therefore not excluded on that basis from the service area of a Part D plan. Thus, they are eligible for Part D, provided that they meet the other Part D eligibility requirements.

A permanent residence is normally the primary residence of an individual. Generally, permanent residence is established by the address provided by the individual, but a PDP sponsor may request additional information, such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, or utility bills if there is a question. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the PDP sponsor must

contact the individual to confirm that the individual lives in the service area. If there is a dispute over where the individual permanently resides, the PDP sponsor should determine whether, according to the law of the State, the person would be considered a resident of that State. *Additional instructions regarding disenrollment of members who may live out of the sponsor's service can be found in §40.2.1 of this guidance.*

Separately, individuals may have mailing addresses that may or may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, such as that of a relative for example, PDP sponsors should make every effort to accommodate these requests, and should use this address to provide the required notices in this guidance and other plan mailings as appropriate. The model PDP enrollment forms provided in this guidance include a mechanism to collect an alternate mailing address. Use of an alternate mailing address does not eliminate or change the residency requirement for the purposes of PDP eligibility.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

Additional information regarding residence for individuals that are auto enrolled or facilitated enrolled is provided in §40.2.1 of this guidance.

10.3 - Completion of Enrollment Request

Unless otherwise specified by CMS, an eligible individual enrolls in a PDP by completing and submitting an enrollment request to the PDP organization, providing all of the required information to complete enrollment within required time frames. Furthermore, transferring from one PBP to another within the same organization is still an enrollment request and must be handled as any other enrollment request. An individual who switches from one benefit package to another with the same PDP sponsor must complete an enrollment request within the required time frames. Such individuals may use a short enrollment form to request enrollment in the new plan offered by the same sponsor. Enrollment request formats include paper enrollment forms and other mechanisms approved by CMS and offered by the PDP organization. The model enrollment form is provided in **Exhibit 1**. The model short enrollment form is provided in Exhibit 1b.

Except as permitted by CMS for individuals enrolling in a PDP by other means, a PDP sponsor must deny enrollment to any individual who does not properly complete an enrollment request within required time frames. Procedures for completing enrollment requests are provided in §30.2.

10.4 – Other Coverage Through an Employer/Union Group

CMS systems will compare Part D enrollment transactions to information regarding the existence of employer or union coverage for which the beneficiary is also being claimed

for the Retiree Drug Subsidy (RDS). If there is a match indicating that the individual may have such other coverage, the enrollment will be conditionally rejected by CMS systems with a transaction reply code (TRC) 127 (see CMS' Plan Communications User Guide for information on TRCs).

Within 10 calendar days of receipt of the Code 127 conditional rejection, the PDP sponsor must contact the individual *by phone or letter* to confirm the individual's intent to enroll in Part D (see Exhibit 5), and that the individual understands the implications of enrollment in a Part D plan on his or her employer/union coverage. The individual will have 30 calendar days from the date he or she is contacted or notified to respond. The PDP sponsor may contact the individual in writing (see Exhibit 5) or by phone and must document this contact and retain it with the record of the individual's enrollment request. If the individual indicates that s/he is fully aware of any consequence to his/her employer/union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the PDP sponsor must update the transaction with the appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and re-submit it for enrollment. The effective date of enrollment will be based on the receipt of the beneficiary's initial enrollment request, not when the individual confirms that s/he wants to enroll. This effective date may be retroactive in the event that the confirmation step occurs after the effective date. *In these cases, sponsors may utilize the Code 62 enrollment transaction code to submit the enrollment transaction directly to CMS as provided in the Plan Communications User Guide (PCUG).*

PDP sponsors are encouraged to closely monitor their outreach efforts and to follow up with applicants prior to expiration of the 30 day timeframe. If the individual does not respond in 30 days, *or responds and declines the enrollment*, the enrollment must be denied. A denial notice must be provided (see Exhibit 6).

When an employer or union group sponsored PDP is replacing an existing RDS plan offered by that employer or union group, the PDP sponsor may receive the Code 127 conditional rejection. In these cases it is not necessary to contact each individual, as described above. The PDP sponsor must resubmit the transactions updated with the appropriate flag.


PDP sponsors should work in close collaboration with employer/union sponsors who are replacing RDS coverage with Part D coverage to ensure that all individuals are aware of the change and have the information they need.

10.5 – Passive Enrollment by CMS

Under Medicare laws and regulations, Medicare beneficiaries must make an enrollment request to enroll in a Part D plan, and CMS specifies the form and manner in which such enrollment requests are made. CMS has determined that it is legally permissible to provide for enrollment in a Part D plan under a passive enrollment request process in specific, limited circumstances generally associated with either immediate plan

terminations or in other situation where CMS determines that remaining enrolled in the plan would pose potential harm to members.

Passive enrollment is a process by which a beneficiary is informed that he or she will be considered to have made a request to enroll in a new Part D plan by taking no action. CMS will determine when passive enrollment is appropriate and will initiate contact through the Part D sponsor's CMS account manager. CMS will provide specific instructions directly to the affected plan(s), including instructions on required beneficiary notifications and any required transaction submissions to CMS.



20 – Enrollment and Disenrollment Periods and Effective Dates

42 CFR 423.38

In order for a PDP sponsor to accept an enrollment or disenrollment request, a valid request must be made during an available enrollment period. It is the responsibility of the PDP sponsor to determine the enrollment period of each enrollment request. There are 3 periods in which an individual may enroll in and/or disenroll from a PDP:

- The Initial Enrollment Period for Part D (IEP for Part D);
- The Annual Coordinated Election Period (AEP);
- All Special Enrollment Periods (SEP).

During the AEP and SEP, individuals may enroll in and disenroll from a PDP plan, or choose another PDP plan. Individuals may enroll in a PDP during the IEP for Part D. Each individual has one election per enrollment period; once an enrollment or disenrollment becomes effective, the election has been used.

All PDP sponsors must accept enrollments into their PDP plans during the AEP, an IEP for Part D, and an SEP. PDP enrollment periods coordinate with similar periods in Medicare Advantage (MA) to accommodate enrollment in MA plans with a Part D benefit (MA-PD plans).

The last enrollment or disenrollment choice made during an enrollment period, determined by the date a request was received by the PDP sponsor, will be the choice that becomes effective. As outlined in CMS' systems guidance for PDP sponsors (and MA organizations), the enrollment transaction will include this information (the "application date").

20.1 – Initial Enrollment Period for Part D (IEP for Part D)

The initial enrollment period is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when an individual is entitled to Part A OR enrolled in Part B, AND lives in the service area of a Part D plan.

At the beginning of the Part D program, there was an IEP for Part D for all current Medicare beneficiaries and individuals who became eligible for Medicare in January 2006 that began on November 15, 2005 and ended May 15, 2006.

Individuals who are becoming eligible for Medicare will have an Initial Enrollment Period for Part D that is the 7 month period surrounding Medicare eligibility (same as the IEP for Part B). The IEP for Part B is the 7-month period that begins 3 months before the month an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility. See 42 CFR §407.14.

For those not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B have an initial enrollment period for Part D that is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D.

Individuals eligible for Medicare prior to age 65 (such as for disability) will have another Initial Enrollment Period for Part D based upon attaining age 65.

If a Medicare entitlement determination is made retroactively, eligibility for Part D begins with the month in which the individual received notification of the retroactive entitlement decision. Therefore, the Part D IEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for three additional months after the month the notice is provided. The effective date is generally the first day of the month after the PDP sponsor receives a completed enrollment request.

Ultimately, CMS provides a part D eligibility effective date and maintains it in CMS systems.

Example 1 -- IEP for Part D surrounding 65th birthday:

Mrs. Smith's 65th birthday is April 20, 2010. She is eligible for Medicare Part A and her Part B initial enrollment period begins on January 1, 2010. Therefore, her IEP for Part D begins on January 1, 2010, and ends on July 31, 2010.

Example 2 -- IEP for working individual:

Mr. Hackerman's 65th birthday is March 23, 2010. He is currently working, and while he signed up for his Medicare Part A benefits, effective March 1, 2010, he declined his enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, December 2009 – June 2010. Hence, his IEP for Part D is also December 2009 – June 2010.

Example 3 -- IEP exception for Part D:

Mr. Duke lived in Italy at the time of his 65th birthday, which occurred on August 3, 2008. His Part B initial enrollment period began on May 1, 2008, and ended November 30, 2008. He plans to return to the U.S. to reside permanently in June 2010. Since he lived out of the U.S. and was not eligible to enroll in a Part D plan during his IEP for Part B, his initial enrollment period for Part D will occur when he meets all the eligibility requirements for Part D, that is, when he has Part A or B and lives in a plan service area. His IEP for Part D is March 2010 – September 2010.

Example 4 -- IEP for retroactive Medicare determination:

Mr. Schlosser received notification of his Medicare determination on June 15, 2010. He was informed in this notice that Medicare Part A will be effective as of July 1, 2009.

Therefore, his Part D initial enrollment period begins in June 2010 and ends September 30, 2010.

Once an individual uses his/her IEP for Part D enrollment and this enrollment becomes effective, this enrollment period ends. Refer to the table in §20.4 of this guidance for effective date information.

20.2 – Annual Coordinated Election Period (AEP)

The AEP occurs November 15 through December 31 of every year. It is also referred to as the “Fall Open Enrollment” season in Medicare beneficiary publications and other tools.

There is one AEP enrollment/disenrollment choice available for use during this period. Once the enrollment/disenrollment is effective, the individual has exhausted this choice.

Refer to §§20.4 and 20.5 for effective date information.

20.3 - Special Enrollment Periods - (SEP)

Special enrollment periods constitute periods outside of the usual IEP, AEP or OEP when an individual may elect a plan or change his or her current plan election. As detailed below, there are various types of SEPs, including SEPs for dual eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet “exceptional conditions” as CMS may provide, consistent with §1860D-1(b) of the Act and §423.38(c) of the Part D regulations.

Depending on the nature of the particular special election period, an individual may take a variety of actions, including:

- Discontinuing an enrollment in a Part D plan and enrolling in Original Medicare
- Switching from Original Medicare to a Part D plan
- Switching from one Part D plan to another Part D plan

Certain SEPs may be limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the PDP, the individual may subsequently enroll in a new Part D plan within the SEP time period. Once the individual has enrolled in a new Part D plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP ends when the individual enrolls in a new Part D plan or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP.**

Note: An individual’s eligibility for an SEP does not convey eligibility to enroll in the plan; in addition to having a valid enrollment period an individual must also meet all applicable Part D eligibility criteria.

It is generally the responsibility of the PDP sponsor to determine whether the individual is eligible for the SEP. The exception to this determination requirement would be enrollment requests completed by or approved by CMS. To make this determination, the organization may need to contact the individual to obtain the information or may obtain this information on the enrollment request by incorporating specific statements regarding SEP eligibility (see Exhibit 1a). Unless otherwise required in this guidance, the organization **MUST** accept verbal or written confirmation from the individual regarding the conditions that make him or her eligible for the SEP. Organizations that obtain this information on the enrollment request are not required to obtain an additional verbal or written confirmation of SEP eligibility.

For enrollment requests obtained during a face-to-face interview or telephone request, the determination of SEP eligibility can be made at that time. For enrollment requests made using paper, internet or the Medicare OEC (without accompanying CMS approval), the sponsor is not required to contact the applicant to confirm SEP eligibility if the enrollment request includes the applicant's attestation of SEP eligibility.

If SEP eligibility is obtained orally (by phone), the sponsor must document this contact and retain this with the enrollment record. If the sponsor obtains this confirmation through a written notice, such notice must include the option (and information) needed to call the sponsor and confirm this information verbally. The organization must obtain this confirmation in accordance with §30.2.2. If the sponsor is not able to obtain this confirmation, the sponsor must deny the enrollment request and provide the individual a notice of denial of enrollment (see Exhibit 6).

The following are examples of questions that might be used to determine eligibility for an SEP:

Type of SEP?	Examples of Questions
Change in Residence	Have you recently moved? If so, when? Where did you move from?
Employer/Union Group Health Plan	Do you currently have (or are leaving) coverage offered by an employer or union? Have you recently lost such coverage?
Disenroll from Part D to enroll in Creditable Coverage	Are you a member of TriCare? Do you want to obtain VA benefits?
Dual Eligible	Do you currently have Medicaid coverage? Does your state pay for your Medicare premiums? Did you recently receive a yellow letter from Medicare (for full duals)?

	Have you recently lost coverage under Medicaid?
Other Low Income Subsidy	Do you receive extra help? Have you recently received a green letter from Medicare? Did you receive a letter from Medicare letting you know that you automatically qualify for extra help? Do you receive SSI cash benefits without Medicaid?
Institutionalized	Are you moving into or are you a current resident of an institution, such as a nursing facility or long-term care hospital? Are you moving out of such a facility?
MA “open enrollment period”	If during January – March: Were you recently a member of a Medicare Advantage plan which included Medicare prescription drug coverage?
PACE	For enrollment – are you currently enrolled in a special plan called “PACE”?

Please note that the time frame of an SEP denotes the time frame during which an individual may make an enrollment or disenrollment request. It does not necessarily correspond to the effective date of the actual enrollment or disenrollment. For example, if an SEP exists for an individual from May through July, then a PDP sponsor must receive an enrollment or disenrollment request from that individual sometime between May 1 and July 31 in order to consider the request to have been made during the SEP. However, the type of SEP will dictate the effective date of coverage, and that effective date of coverage can occur after July 31. The following discussion of SEPs and their corresponding effective dates will demonstrate this concept more fully.

20.3.1 - SEPs for Changes in Residence

An SEP for changes in residence exists for these scenarios:

- 1) individuals who are no longer eligible to be enrolled in a PDP due to a change in permanent residence outside of the PDP’s service area;
- 2) individuals who were not eligible for Part D because they have been out of the U.S. and have now moved back to the U.S.;
- 3) individuals who were not eligible for Part D because they were incarcerated and have now been released;

- 4) individuals who will have new Medicare health or Part D plans available to them as result of a permanent move.

Since individuals who do not permanently reside in the plan service area are ineligible for the plan and must be disenrolled, a SEP is not needed to effectuate an involuntary disenrollment for that reason (see §40.2.1). Individuals who move and have new Medicare health or Part D plans available to them as a result of the move, but continue to reside in the current plan service area, may use this SEP to enroll in a different plan.

When the individual notifies the organization of a permanent move out of the plan service area, the SEP begins either the month before the individual's permanent move, if the individual notifies the organization in advance, or the month the individual provides the notice of the move, if the individual has already moved. The SEP continues for two months following the month it begins or the month of the move, whichever is later. If the plan learns from CMS or U.S. Post Office (as described in §40.2.1) that the individual has been out of the service area for over six months and the plan has not been able to confirm otherwise with the individual, the SEP will begin at the beginning of the sixth month and continues through to the end of the eighth month.

The SEP permits enrollment elections only. The effective date *of the enrollment* is associated with the date the PDP sponsor receives the completed enrollment request. The individual may choose an effective date of up to three months after the month in which the PDP sponsor receives the enrollment request. However, the effective date may not be earlier than the date the individual moves to the new service area and the PDP sponsor receives the completed enrollment request.

EXAMPLES:

Example 1:

A beneficiary is a member of a PDP in Florida and intends to move to Arizona on June 18. An SEP exists for this beneficiary from May 1 through August 31.

- A. If a PDP sponsor in Arizona receives a completed enrollment form from the beneficiary in May and since the individual is not moving to the new service area until June 18th, the beneficiary can choose an effective date of July 1, August 1, or September 1.
- B. If the PDP sponsor receives the completed enrollment form from the beneficiary in June (the month of the move) the beneficiary can choose an effective date of July 1, August 1, or September 1.
- C. If the PDP sponsor receives the completed enrollment form in July, the beneficiary can choose an effective date of August 1, September 1, or October 1.

Example 2:

A beneficiary resides in Florida and is currently in Original Medicare and not enrolled in a PDP. The individual intends to move to Maryland on August 3. An SEP exists for this beneficiary from July 1 through October 31.

At the time the individual enrolls in a PDP, the individual must provide the specific address where s/he will permanently reside upon moving into the service area, so that the PDP sponsor can determine that the individual meets the residency requirements for enrollment in the plan.

Disenrollment from Previous PDP

Please keep in mind that a member of a PDP who moves permanently out of the service area must be *involuntarily* disenrolled from the plan. A member of a PDP who resides out of the *service* area for over six months must be *involuntarily* disenrolled from the plan. CMS has established an SEP that allows an individual adequate time to choose a new PDP, given the fact that the individual will no longer be enrolled in the original PDP after the month of the move or after the sixth month (whichever is appropriate).

20.3.2 – SEP for Dual-eligible Individuals or Individuals Who Lose Their Dual-eligibility

There is an SEP for individuals who are entitled to Medicare Part A and/or Part B and receive any type of assistance from the Title XIX (Medicaid) program. This also includes individuals often referred to as “partial duals” who receive cost sharing assistance under Medicaid (e.g. QMB, SLMB, etc). This SEP begins the month the individual becomes dually-eligible and exists as long as s/he receives Medicaid benefits. This SEP allows an individual to enroll in, or disenroll from, a Part D plan. The effective date of the individual’s enrollment in their new plan would be the first of the month following receipt of an enrollment request. However, as described in 30.1.4, the effective date for auto-enrollments may be retroactive.

In addition, PDP eligible individuals no longer eligible for benefits under Title XIX benefits will have an SEP beginning with the month they lose eligibility plus two additional months to make an enrollment choice in another PDP, an MA-PD, or to disenroll entirely from Part D.

20.3.3 - SEPs for Contract Violation

In the event an individual is able to demonstrate to CMS that the PDP sponsor offering the PDP of which he/she is a member substantially violated a material provision of its contract under Part D in relation to the individual by, but not limited to:

- failure to provide the individual on a timely basis benefits available under the plan;
- failure to provide benefits in accordance with applicable quality standards; or

- the PDP sponsor (or its agent) materially misrepresented the PDP when marketing the PDP,

the individual may disenroll from the PDP and enroll in another Part D plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately enrolls in a new Part D plan upon disenrollment from the original PDP.

We note that in some case-specific situations, CMS may process a retroactive disenrollment for these types of disenrollments. If the disenrollment is not retroactive, an SEP exists such that an individual may elect another Part D plan during the last month of enrollment in the PDP sponsor, for an effective date of the month after the month the new PDP sponsor receives the completed enrollment request.

EXAMPLE

On January 16, CMS determines, based on a member's allegations, that the PDP sponsor substantially violated a material provision of its contract. As a result, the member will be disenrolled from the PDP on January 31. An SEP exists for this beneficiary beginning January 16 and lasting until the end of January. The beneficiary promptly applies for a new Part D plan, and the new PDP sponsor receives a completed enrollment request on January 28 for a February 1 effective date.

If the individual in the above example did not enroll in another PDP on January 28th, s/he would have an additional 90 calendar days from the effective date of the disenrollment from the first PDP to elect another PDP. The individual may choose an effective date of enrollment in a new PDP beginning any of the three months after the month in which the PDP sponsor receives the completed enrollment request. However, the effective date may not be earlier than the date the PDP sponsor receives the completed enrollment request.

EXAMPLE

On January 16, CMS determines, based on a member's allegations that the PDP sponsor substantially violated a material provision of its contract. As a result, the member disenrolls from the PDP on January 31. A 90-day SEP continues to exist for the beneficiary from February 1 through April 30. In this example, a new PDP sponsor then receives a completed enrollment request from the individual on April 15. The beneficiary may choose an effective date of May 1, June 1, or July 1.

If the disenrollment is retroactive, CMS will provide the beneficiary with the time frame for his/her SEP to enroll in another Part D plan. Depending on the circumstance surrounding the contract violation, CMS may determine a retroactive enrollment into another plan is warranted.

20.3.4 - SEPs for Non-renewals or Terminations

In general, SEPs are established to allow members affected by PDP non-renewals or terminations ample time to make a choice of another PDP. Effective dates during these SEPs are described below. CMS has the discretion to modify this SEP as necessary for any non-renewal or termination when the circumstances are unique and warrant a need for a modified SEP.

In particular:

- **Non-renewals** - An SEP exists for members of a PDP that will be affected by a plan or contract non-renewal that is effective January 1 of the contract year. For this type of non-renewal, PDP sponsors are required to *provide advance* notice to affected members *within timeframes specified by CMS. In order to provide sufficient time for members to evaluate their options*, the SEP begins October 1 and ends on January 31 of the following year.

During this SEP, a beneficiary may choose an effective date of November 1, December 1, January 1, or February 1; however, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request. *Only enrollment requests received in January will have an effective date of February 1.*

- **PDP Sponsor Termination of Contract and Terminations/Contract Modifications by Mutual Consent** - An SEP exists for members of a PDP who will be affected by a termination of contract by the PDP sponsor or a modification or termination of the contract by mutual consent (see 42 CFR §423.508 for contract requirements regarding terminations). For this type of termination or modification, PDP sponsors are required to give notice to affected members at least 60 calendar days prior to the proposed date of termination or modification. To coordinate with the notification time frames, the SEP begins two months before the proposed termination effective date, and ends one month after the month in which the termination occurs.

Please note that if an individual does not enroll in another PDP before the termination effective date, he/she will be disenrolled on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently enroll in a PDP (for a prospective, not retroactive, effective date).

Beneficiaries affected by these types of terminations may request an effective date of the month after notice is given, or up to two months after the effective date of the termination. However, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request.

EXAMPLE

If a PDP sponsor contract terminates for cause on April 30, an SEP lasts from March 1 through May 31. In this scenario, a beneficiary could choose an effective date of April 1, May 1, or June 1 in a new PDP; however, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request.

- **CMS Termination of PDP Sponsor Contract** - An SEP exists for members of a PDP that will be affected by PDP sponsor contract terminations by CMS (see 42 CFR §423.509 for contract requirements on terminations). For this type of termination, PDP sponsors are required to give notice to affected members at least 30 calendar days prior to the effective date of the termination (see 42 CFR §423.509(b)(1)(ii)). To coordinate with the notification time frames, the SEP begins 1 month before the termination effective date and ends 2 months after the effective date of the termination.

Please note that if an individual does not enroll in a new PDP before the termination effective date, he/she will be disenrolled on the effective date of the termination. However, the SEP will still be in effect for two months after the effective date of the termination should the individual wish to subsequently enroll in another PDP (for a prospective, not retroactive, effective date).

Beneficiaries affected by these types of terminations may choose an effective date of up to three months after the month of termination. However, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request.

EXAMPLE

If CMS terminates a PDP sponsor contract effective June 30, an SEP lasts from June 1 through August 31. In this scenario, a beneficiary could choose an effective date of July 1, August 1, or September 1; however, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request.

- **Immediate Terminations By CMS** - CMS will establish the SEP during the termination process for immediate terminations by CMS (see 42 CFR §423.509(b) (2) for immediate termination requirements), where CMS provides notice of termination to the PDP enrollees and the termination may be mid-month.

20.3.5 - SEP for Involuntary Loss of Creditable Prescription Drug Coverage

This SEP applies to individuals who involuntarily lose creditable prescription drug coverage, including a reduction in the level of coverage so that it is no longer creditable, not including any such loss or reduction due to the individual's failure to pay premiums. The SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends 2 months after either the loss (or reduction) occurs or the individual received the notice, whichever is later. The effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be prospective; however, it may be no more than 2 months from the end of the SEP.

20.3.6 - SEP for Individuals Not Adequately Informed about Creditable Prescription Drug Coverage

This SEP applies to individuals who were not adequately informed of the creditable status of drug coverage provided by an entity required to give such notice, or a loss of creditable coverage. This SEP permits one enrollment in, or disenrollment from, a PDP on a case-by-case-basis. This SEP begins the month the individual receives CMS approval of the SEP and continues for two additional months following this approval.

20.3.7 - SEP for Enrollment/Non-enrollment in Part D due to an Error by a Federal Employee

An individual whose enrollment or non-enrollment in Part D is erroneous due to an action, inaction or error by a Federal Employee is provided an SEP. This SEP permits enrollment in or disenrollment from a PDP on a case-by-case basis. This SEP begins the month the individual receives CMS approval of the SEP and continues for two additional months following this approval.

20.3.8 - SEPs for Exceptional Conditions

CMS has the legal authority to establish SEPs when an individual or group of individuals meets exceptional conditions specified by CMS, including on a case-by-case basis. The SEPs CMS has established include:

1. SEP EGHP (Employer/Union Group Health Plan)- An SEP exists for individuals enrolling in employer/union group-sponsored Part D plans, for individuals to disenroll from a Part D plan to take employer/union-sponsored coverage of any kind, and for individuals disenrolling from employer/union-sponsored coverage (including COBRA coverage) to enroll in a Part D plan. The SEP EGHP may be used when the EGHP allows the individual to make changes to their plan choices, such as during the employer's or union's "open season," or at other times the employer or union allows.

This SEP is available to individuals who have (or are enrolling in) an employer or union plan and ends 2 months after the month the employer or union coverage ends.

The individual may choose the effective date of enrollment or disenrollment, up to 3 months after the month in which the individual completes an enrollment or disenrollment request. However, the effective date may not be earlier than the first of the month following the month in which the request was made.

Keep in mind that all PDP eligible individuals, including those in EGHPs, may enroll in a PDP during the IEP for Part D, AEP and during any other SEP. The SEP EGHP does not eliminate the right of these individuals to enroll or disenroll during these time frames. Additionally, §50.5 outlines special processes that are available for enrollment into or disenrollment from EGHP sponsors Part D plan.

2. SEP for Individuals Who Disenroll in Connection with a CMS Sanction - On a case-by-case basis, CMS will establish an SEP if CMS sanctions a PDP sponsor, and an enrollee disenrolls in connection with the matter that gave rise to that sanction. The start/length of the SEP, as well as the effective date, is dependent upon the situation.

3. SEP for Individuals Enrolled in Cost Plans that are Non-renewing their Contracts

An SEP will be available to enrollees of HMOs or CMPs that are not renewing their §1876 cost contracts for the area in which the enrollee lives if the individual is also enrolled in a Part D benefit through that Cost Plan.

This SEP is available only to Medicare beneficiaries who are enrolled in the Part D benefit through an HMO or CMP under a §1876 cost contract that will no longer be offered in the area in which the beneficiary resides. Beneficiaries electing to enroll in a PDP via this SEP must meet PDP eligibility requirements.

This SEP begins 90 calendar days prior to the end of the contract year (i.e., October 1) and ends on December 31 of the same year.

During this SEP, a beneficiary may choose an effective date of November 1, December 1, or January 1; however, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request.

4. SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE) -

Individuals may disenroll from a PDP at any time in order to enroll in PACE, including the PACE Part D benefit. In addition, individuals who disenroll from PACE have an SEP for up to 2 months after the effective date of PACE disenrollment to enroll in a PDP. The effective date would be dependent upon the situation.

5. SEP for Institutionalized Individuals – An SEP will be provided to an individual who moves into, resides in, or moves out of a:

- Skilled nursing facility (SNF) as defined in §1819 of the Act (Medicare);

- Nursing facility (NF) as defined in §1919 of the Act (Medicaid);
- Intermediate care facility for the mentally retarded (ICF/MR) as defined in §1905(d) of the Act;
- Psychiatric hospital or unit as defined in §1861(f) of the Act;
- Rehabilitation hospital or unit as defined in §1886(d)(1)(B) of the Act;
- Long-term care hospital as defined in §1886(d)(1)(B) of the Act; or
- Hospital that has an agreement under §1883 of the Act (a swing-bed hospital).

In addition, for individuals who move out of one of the facilities listed above, the individual will have an SEP for up to 2 months after he/she moves out of the facility. This SEP permits an individual to enroll in, or disenroll from, a Part D plan. The effective date is the first of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

Please note the definition of “institution” here differs from that used in determining when an institutionalized full-benefit dual eligible qualifies for the low-income subsidy copayment level of zero.

6. SEP for Individuals Who Enroll in Part B during the Part B General Enrollment Period (GEP) – An SEP will be provided to individuals who are not entitled to premium free Part A and who enroll in Part B during the General Enrollment Period for Part B (January – March) for an effective date of July 1st. The SEP will begin April 1st and end June 30th, with an effective date of July 1st.

7. SEP for Non-Dual Eligible Individuals with LIS and Individuals who Lose LIS - Individuals who qualify for LIS (but who do not receive Medicaid benefits) have an SEP that begins the month the individual becomes eligible for LIS and exists as long as s/he is eligible for LIS. This SEP allows an individual to enroll in, or disenroll from, a Part D plan at any time. Because this coverage is effective the first of the month, the SEP would permit beneficiaries to change enrollment on a monthly basis, if they so choose. The effective date for enrollments under this SEP will be prospective, effective the first day of the month following receipt of the enrollment request by the plan.

Example: An individual is awarded LIS and CMS facilitates his enrollment into a PDP, effective October 1st; in November, the individual decides he would rather be enrolled in another PDP and submits a request in November. He does so using this SEP and his enrollment is effective December 1st.

Individuals who lose their LIS eligibility for the following calendar year will have an SEP to make a change during January – March. Those individuals who lose eligibility for LIS during the year outside of this annual process will have an SEP that begins the month they are notified *by the PDP* and continues for two months.

8. *Part D SEPs to Coordinate With MA Enrollment Periods* – The following Part D SEPs are established to coordinate with election periods in the MA program. More

information about MA election periods can be found in MA Enrollment and Disenrollment Guidance (MMCM Chapter 2).

A. SEP for MA-PD enrollee using the MA SEP65 - MA eligible individuals who elect an MA plan during the initial coverage election period (ICEP) surrounding their 65th birthday have an SEP called the “SEP65.” The SEP65 allows the individual to disenroll from the MA plan and elect the Original Medicare plan any time during the 12-month period that begins on the effective date of coverage in the MA plan. If the individual using the SEP65 is disenrolling from an MA-PD plan, he or she may (but is not required to) use this Part D SEP to enroll in a PDP plan. This SEP must be used at the same time the SEP65 is used.

B. SEP for Individuals Who Dropped a Medigap Policy When They Enrolled For the First Time in an MA Plan, and Who Are Still in a “Trial Period” – Individuals who dropped a Medigap policy when they enrolled for the first time in an MA plan are provided a guaranteed right to purchase another Medigap policy if they disenroll from the MA plan while they are still in a “trial period.” In most cases, a trial period lasts for 12 months after a person enrolls in an MA plan for the first time. If the individual is using this SEP to disenroll from an MA-PD plan, there is a Part D SEP to permit a *one*-time enrollment into a PDP. This SEP opportunity may only be used in relation to the MA SEP described here and begins the month they disenroll from the MA-PD plan and continues for two additional months.

C. SEP for an MA-PD enrollee using the MA Open Enrollment Period for Institutionalized Individuals (OEPI) to disenroll from an MA-PD plan - Individuals that meet the definition of “institutionalized” as it is provided in, and applies to, section 30.3.2 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2) are eligible for the OEPI election period. An individual disenrolling from an MA-PD plan has an OEPI to enroll in a PDP. This OEPI begins with the month the individual requests disenrollment from the MA-PD plan and ends on the last day of the second month following the month MA-PD membership ended.

D. SEP to enroll in a Part D plan - MA-PD enrollees using the MA OEP to disenroll from MA - Individuals enrolled in MA-PD plans using the MA Open Enrollment Period (OEP) to disenroll from MA must maintain Part D enrollment by enrolling in another Part D plan, such as a PDP or the Part D optional supplemental benefit offered by a cost plan. This SEP permitting enrollment into a PDP is in effect for MA-PD enrollees during the OEP each year and is limited to one enrollment.

E. SEP to enroll in a Part D plan - MA-PD enrollees using the MA OEPNEW to disenroll from MA - Individuals enrolled in MA-PD plans using the MA Open Enrollment Period for newly eligible individuals (OEPNEW) to disenroll from MA must maintain Part D enrollment by enrolling in another Part D plan, such as a PDP or the Part D optional supplemental benefit offered by a cost plan. This SEP permits enrollment into a PDP for MA-PD enrollees during their OEPNEW and is limited to one enrollment.

F. SEP for enrollment into MA SNPs or enrollment into a PDP after loss of special needs status - CMS is establishing an SEP to allow for disenrollment from a PDP at any time in order to enroll in an MA SNP. In addition, CMS will provide an SEP to enroll in a PDP for those who are no longer eligible for a SNP because they no longer meet special needs status (as outlined in MA Enrollment and Disenrollment Guidance – MMCM, Chapter 2). This SEP begins the month the individual's special needs status changes and ends the earlier of when the beneficiary makes an election or three months after the effective date of the involuntary disenrollment. The effective date would be dependent upon the situation.

G. SEP for Enrollment into a Chronic Care SNP and for Individuals found ineligible for a Chronic Care SNP - CMS will provide an SEP (for MA and Part D) for those individuals with severe or disabling chronic conditions to enroll in a SNP designed to serve individuals with those conditions. This SEP will apply as long as the individual has the qualifying condition and will end once s/he enrolls in a SNP. Once the SEP ends, that individual may make enrollment changes only during applicable MA election periods. In addition, individuals enrolled in a Chronic Care SNP who have a severe/disabling chronic condition which is not a focus of their current SNP are eligible for this SEP. Such individuals have an opportunity to enroll in a Chronic Care SNP that focuses on this other condition. Eligibility for this SEP ends at the time the individual enrolls in the new SNP.

Individuals who are found after enrollment not to have the qualifying condition necessary to enroll in a chronic/disabling condition Special Needs MA-PD Plan will have an SEP to enroll in a different MA-PD plan or MA-only plan with accompanying Part D coverage. This would normally occur when the required post enrollment verification with a provider did not confirm the information provided on the pre-enrollment assessment tool. This SEP begins when the plan notifies the individual of the failure to qualify and extends through the end of that month as well as the following two months. The SEP ends when the individual makes an enrollment election or on the last day of the second of the two months following notification. Any enrollments made during this election period are for prospective effective dates.

H. SEP for Individuals Involuntarily Disenrolled from an MA-PD plan due to loss of Part B - Individuals who are involuntarily disenrolled from an MA-PD plan due to loss of Part B but who continue to be entitled to Part A have a SEP to enroll in a PDP. The SEP begins when the individual is advised of the loss of Part B and continues for two additional months.

9. SEP for Individuals who belong to a Qualified SPAP or who lose SPAP eligibility -- Individuals who belong to a qualified SPAP are eligible for an SEP to make one enrollment choice at any time through the end of each calendar year (i.e., once per calendar year). SPAP members, or the State acting as the authorized representative of members, may use this SEP to enroll in a Part D plan outside of existing enrollment

opportunities, allowing them, for example, to join a Part D plan upon becoming a member of an SPAP; or to switch to another Part D plan.

In addition, individuals no longer eligible for SPAP benefits will have an SEP beginning with the month they lose eligibility plus two additional months to make an enrollment choice in another PDP or MA-PD.

10. Full-Benefit Dual Eligibles With Retroactive Uncovered Months – In limited instances, a full-benefit dual eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled. Due to the earlier enrollment a coverage gap may occur. To reduce the impact of the coverage gap, the PDP is required to make the voluntary enrollment retroactive per Section 30.1.4.B.

11. SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage – Individuals may disenroll from a Part D plan (including PDPs and MA-PDs) to enroll in or maintain other creditable drug coverage (such as TriCare or VA coverage). The effective date of disenrollment is the first day of the month following the month a disenrollment request is received by the Part D plan.

12. SEP for Individuals disenrolling from a Cost plan who also had the Cost plan optional supplemental Part D benefit – Individuals who disenroll from a cost plan and the cost plan's optional supplemental Part D benefit have an SEP to enroll in a **PDP**. This SEP begins the month the individual requests disenrollment from the cost plan and ends when the individual makes an enrollment election or on the last day of the second month following the month cost plan membership ended, whichever is earlier.

20.4 - Effective Date of Enrollment

With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not request their effective date of enrollment in a PDP. Furthermore, unless provided for under an SEP (e.g. EGHP or full dual retroactive as discussed in the previous section), the effective date can never be prior to the receipt of an enrollment request by the PDP sponsor. An enrollment cannot be effective prior to the date the beneficiary (or their legal representative, if applicable) completed the enrollment request. This section includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.

To determine the proper effective date, the PDP sponsor must determine which enrollment period applies to each individual before the enrollment may be transmitted to CMS. This period may be determined by reviewing information such as the individual's date of birth, Medicare card, and by the date the PDP sponsor receives the enrollment request.

Once the PDP sponsor identifies the enrollment period, the PDP sponsor must determine the effective date. In addition, PDP enrollments for EGHP sponsored PDP plans and full

benefit dual eligible enrollments may be retroactive under certain circumstances (refer to §50.5 for more information on EGHP retroactive effective dates).

Examples for determining the effective date:

- A. On August 18, 2010, Mrs. Jones submits an enrollment request to a PDP sponsor. Her enrollment form shows she became entitled to Medicare Parts A and B in March 2002. She has indicated on her enrollment form that she lives in a long-term care facility. What is her effective date?

Explanation: Since the date the request was received is August 18, 2007, this is not an AEP request. The entitlement date for Medicare Parts A and B shows that she is not in her IEP for Part D. That leaves only an SEP. Mrs. Jones indicated that she resides in a long-term care facility, so this enrollment request can be processed under the SEP for Institutionalized Individuals (see §20.3.8, item # 5). The effective date for this enrollment is September 1, 2010.

- B. Mr. Doe calls a PDP sponsor for information about Part D on October 3, 2010. The PDP representative discusses the PDP plans available and the enrollment requirements, including when an individual may enroll. Mr. Doe tells the representative that he is retiring and his employer coverage will end on October 31, 2010. He submits an enrollment request on October 24, 2010. His entitlement to Medicare Parts A and B is June 1, 1998. He indicates on the request that he does not reside in a long-term care facility.

Explanation: Since the date the request was received is October 24, 2010, this is not an AEP request. The entitlement date for Medicare Parts A and B shows he is not in his IEP for Part D. No other details on the request itself point to any specific enrollment period, however we know that he has retired and his employer sponsored commercial coverage is ending. The enrollment can be processed using the SEP EGHP (see §20.3.8, item # 1). Mr. Doe can choose an effective date of up to 3 months after the month in which the request is made. The PDP sponsor contacts Mr. Doe, confirms his retirement, explains the SEP EGHP and asks him about the effective date. Since his employer coverage is ending on October 31, 2010, he requests a November 1, 2010, effective date.

Effective dates for Enrollment Periods:

Part D Enrollment Period	Effective Date
<u>Annual Coordinated Election Period (AEP)</u> The AEP begins on November 15 and continues through December 31 of every year. Individuals have one AEP enrollment to use – once this enrollment is effective, the AEP has been used.	January 1 st of following year.

<p><u>Initial Enrollment Period for Part D (IEP for Part D)</u> For individuals that become Part D eligible after January 2006, generally the IEP for Part D is concurrent with the initial enrollment period for Part B. (Note: The Initial Enrollment Period for Part B begins 3 months prior to the month of Medicare eligibility, and ends on the last day of the third month following the month of Medicare eligibility.)</p> <p>Example: Mrs. Jones is eligible for Medicare on July 1, 2010. Her Part B Initial Enrollment Period is April 1, 2010 through October 31, 2010. Therefore her IEP for Part D is also July 1, 2010 through October 31, 2010.</p> <p>If individuals had not been eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B or those not eligible for Part D during first Medicare initial enrollment period for Part D that occurred from November 15, 2005 through May 15, 2006, their IEP for Part D is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D.</p> <p>Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP for Part D based upon attaining age 65.</p>	<p>Enrollment requests made prior to the month of eligibility are effective the first day of the month of eligibility.</p> <p>Enrollment requests made during or after the first month of eligibility are effective the 1st of the month following the month the request was made.</p>
<p><u>Special Enrollment Periods (SEP)</u> SEPs for PDP enrollment and disenrollment choices are described in section 20.3 of this guidance.</p>	<p>Effective dates are dependent upon the individual SEP and circumstances.</p>

It is possible for an individual to make an enrollment request when more than one enrollment and disenrollment period applies, and therefore it is possible that more than one effective date could apply. If an individual requests enrollment when more than one enrollment period applies, a PDP sponsor must allow the individual to choose the enrollment period (and therefore the effective date) in which he/she is enrolling (see exception in the next paragraph regarding the IEP for Part D).

If the individual's IEP for Part D and another enrollment period overlap, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

EXAMPLE

If an individual's IEP for Part D starts in November, (i.e., he will be entitled to Medicare Part A and Part B in February) and a PDP sponsor receives an enrollment request from that individual during the AEP, then the individual may NOT choose a January 1 effective date (for the AEP) and must instead be given a February 1

effective date (for the IEP for Part D) because January 1st is earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

If an individual makes an enrollment request when more than one enrollment period applies but does not indicate or choose an effective date as above, then the PDP sponsor must attempt to contact the individual to determine the individual's preference. If unsuccessful, the PDP sponsor must use the following ranking of enrollment periods. The enrollment period with the highest rank determines the effective date in this situation.

Ranking of Enrollment Periods: (1 = Highest, 3 = Lowest)

1. IEP for Part D
2. SEP
3. AEP

20.5 - Effective Date of Voluntary Disenrollment

PDP enrollees may voluntarily disenroll from a PDP during the AEP and SEP as described in §§20.2 and 20.3 of this guidance. With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not choose the effective date of disenrollment. This section includes procedures for handling situations when a beneficiary chooses a disenrollment effective date that is not allowable based on the requirements outlined in this section.

A PDP enrollee may disenroll through the PDP sponsor or 1-800-MEDICARE. If an enrollee enrolls in a new PDP, during an available enrollment period, while still enrolled in another PDP, he/she will automatically be disenrolled from the old PDP and enrolled in the new PDP by CMS systems with no duplication or delay in coverage. Further, individuals enrolled in any MA plan (except for an MA Private Fee-For-Service (PFFS) plan that does not offer a Part D benefit or a Medicare Medical Savings Account (MSA) plan) will be disenrolled from that MA plan upon successful enrollment in a PDP.

As with enrollments, it is possible for an individual to make a disenrollment request when more than one enrollment period applies. Therefore, in order to determine the proper effective date, the PDP sponsor must determine which period applies to the request to determine the effective date of disenrollment before the disenrollment transaction may be transmitted to CMS.

If a PDP sponsor receives a disenrollment request when more than one period applies, the PDP sponsor must allow the member to choose the effective date of disenrollment (from the possible dates, as provided by the enrollment/disenrollment periods that overlap). If the member does not make a choice of effective date, then the PDP sponsor must give the effective date that results in the **earliest** disenrollment. The procedure for determining the enrollment/disenrollment period is the same as described in §20.4 of this guidance.

Effective dates for voluntary disenrollment are as follows. (Refer to §§40.2 and 40.3 for effective dates for involuntary disenrollment.)

Enrollment Period	Effective Date of Disenrollment*	Do PDP sponsors have to accept disenrollment requests in this enrollment period?
Annual Coordinated Election Period	January 1 of the following year.	Yes
Special Enrollment Period	Varies, as outlined in §20.3	Yes

***NOTE:** CMS may allow up to 90 days retroactive payment adjustments for EGHP sponsored PDP disenrollments. Refer to §50.5 for more information.

As stated previously, individuals generally cannot choose the effective date of disenrollment. The enrollment/disenrollment period during which the request is received dictates the effective date. If an individual requests a disenrollment date that is not permissible, the PDP sponsor should advise the individual and process the request according the requirements in this guidance.



30 - Enrollment Procedures

42 CFR 423.32

A PDP sponsor must accept all enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, through CMS auto-enrollment or facilitated enrollment processes, or through other mechanisms defined by CMS (and offered by the PDP sponsor). PDP sponsors may accept faxed enrollment requests and need not obtain the original.

Upon receiving an enrollment request, a PDP sponsor must provide within 10 calendar days, one of the following:

- Notice of acknowledgement (as described in section 30.4.1);
- Request for additional information (as described in 30.2.2); or
- Notice of denial (as described in 30.2.3).

The individual (or his/her legal representative) must complete an enrollment request and include all the information required to process the enrollment, or an enrollment may be generated by other processes specified by CMS. Furthermore, the individual must submit the election to the PDP during a valid enrollment period.

CMS will provide weekly TRRs as well as a monthly TRR. Unless otherwise directed in this guidance, the PDP sponsor must provide notice in response to information received from CMS on either the weekly or monthly TRR, whichever contains the earliest notification.

In limited circumstances, CMS may require PDP sponsors to submit “rollover” transactions as part of the transition from one contract year to another. In these cases, the PDP sponsor must have approval from **CMS** prior to submitting these transactions. When approved, the application date must be set to November 14th of the current year, with an effective date of the following January 1st and the election period identifier value of “X.” *CMS will provide additional instructions for this end-of-year activity every Fall.*

Special Rule for the Annual Coordinated Election Period (AEP):

PDP sponsors may not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP on November 15th. However, CMS recognizes that organizations may receive unsolicited paper enrollment requests prior to the start of the AEP on November 15th since marketing activities may begin on October 1st. If unsolicited paper enrollment forms are received on or after October 1st and prior to November 15th, PDP organizations must retain and process them as follows:

- Within 7 calendar days of the receipt of a complete paper enrollment request, the plan must provide the beneficiary with a written notice that acknowledges receipt of the enrollment request (Exhibit 2), and indicates that the enrollment will take effect

on January 1st effective date of the following year.

- For AEP enrollment requests received prior to November 15th plans must submit all transactions to CMS systems (MARx) on November 15th with an “application date” of November 15th of the current year in the appropriate data field on the enrollment transaction. For example, unsolicited AEP paper enrollment requests received October 1 through November 14, **2010**, must be submitted on November 15, **2010**, with an application date of November 15, **2010**. If a beneficiary has submitted more than one AEP paper enrollment request prior to November 15th, the beneficiary will be enrolled in a plan based on the first application that is processed.
- Once the PDP sponsor receives a MARx TRR from CMS indicating whether the individual’s enrollment has been accepted or rejected, the PDP sponsor must meet the remainder of the requirements (e.g., sending a notice of the acceptance or rejection of the enrollment within 10 calendar days following receipt of the TRR) provided in Section 30.4.

Note: If organizations receive incomplete unsolicited AEP paper enrollment requests prior to November 15th, they must follow existing guidance for working with beneficiaries to complete the applications.

Again, this policy applies only to unsolicited paper enrollment forms requesting an AEP enrollment for January 1st. To help ensure a successful AEP season, it is imperative that plans follow these steps and submit valid enrollment transactions promptly as directed.

30.1 - Format of Enrollment Requests

All PDP sponsors must have, at minimum, a paper enrollment form available for potential enrollees to request enrollment in a PDP. PDP sponsors may also accept enrollment elections made via the on-line enrollment center hosted by CMS, as well as requests for enrollment as described in §§30.1.1 – 30.1.6.

No PDP enrollment request vehicle, regardless of format, may include any question regarding health screening information.

The PDP sponsor’s enrollment vehicle(s) must include important information that the individual acknowledges, including:

- Understands the requirement to continue to keep Medicare Part A or B
- Agrees to abide by the PDP sponsor’s membership rules as outlined in material provided to the member;
- Consents to the disclosure and exchange of information necessary for the operation of the Part D program;

- Understands that enrollment in the PDP automatically disenrolls him/her from any other PDP or MA plan (as described in §10 of this guidance) in which he/she is enrolled; and
- Knows he/she has the right to appeal service and payment denials made by the organization.

Please refer to Appendix 2 for a complete listing of required elements that must be included on enrollment mechanisms and Exhibits 1 – 1b for complete information on the required statements.

Refer to §50.8 for requirements regarding retention of enrollment requests.

30.1.1 - Paper Enrollment Forms

All PDP sponsors must, as a minimum standard, have a paper enrollment form that complies with CMS' guidelines in format and content and a process as described in this guidance for accepting it. A model enrollment form is included in Exhibit 1 and Exhibit 1b.

30.1.2 – Enrollment via the Internet

PDP sponsors may develop and offer enrollment requests into a PDP via the PDP sponsor's secure internet web site. The following guidelines must be applied, in addition to all other program requirements.

- Submit all materials and web pages related to the online enrollment process for CMS approval following the established guidelines for the review and approval of marketing materials and enrollment request vehicles.
- Provide beneficiaries with all the information required by CMS' marketing guidelines for the Part D program.
- The PDP sponsor must, at a minimum, comply with the CMS internet architecture requirements found at: <http://cms.hhs.gov/informationsecurity/> The PDP sponsor may also include additional security provisions.
- Advise each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment request to the PDP sponsor.
- Capture the same data required on the model enrollment form (see Exhibit 1, 1b and Appendix 2).
- As part of the online enrollment process, include a separate screen or page that includes an "enroll now" or "I agree" type of button that the individual must click on to indicate his/her intent to enroll, and agreement to the release and authorization language (as provided on the model enrollment form, see Exhibit 1 and Exhibit 1b) and attest to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.
- Inform the individual of the consequences of completing the internet enrollment, i.e. that s/he will be enrolled (if approved by CMS), and that s/he will receive a

notice (an acceptance or denial notice) following submission of the enrollment to CMS.

- Include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received, for example, a confirmation of receipt number.
- Optionally, may request or collect premium payment or other payment information, such as bank account information or credit card numbers.
- Maintain electronic records that are securely stored and readily reproducible for the period required in this guidance.
- The *option of online enrollment, other than the CMS Online Enrollment Center described below, is limited to requests submitted via the PDP sponsor's website. Online enrollment via other means, such as a broker website, is not permitted.*

Medicare Online Enrollment Center:

In addition to the process described above, CMS offers an on-line enrollment center through the www.medicare.gov web site and the 1-800-MEDICARE call center for enrollment into Medicare prescription drug plans. The date and time “stamped” by the Medicare Online Enrollment Center (OEC) will serve as the enrollment request date (i.e. application date) for purposes of determining the election period and enrollment effective date. PDP sponsors should retrieve OEC requests at least daily.

30.1.3 - Enrollment via Telephone

PDP sponsors may accept enrollment requests into one or more of its PDPs via an incoming (in-bound) telephone call to a plan representative or agent. The following guidelines must be followed, in addition to all other program requirements:

- Enrollment requests may only be accepted from/during an incoming (or in-bound) telephone call from a beneficiary to a plan representative or agent.
- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded and include statements of the individual's agreement to be recorded, required elements necessary to complete the enrollment (as described in Appendix 2), and a verbal attestation of the intent to enroll. All telephonic enrollment recordings must be reproducible and maintained as provided in §50.8 of this guidance.
- Collection of financial information is prohibited at any time during the call.
- A notice of acknowledgement and other required information must be provided to the individual as described in §30.4 of this guidance.

The PDP sponsor must ensure that all Part D eligibility and enrollment requirements provided in this guidance are met.

Scripts for completing an enrollment request in this manner must be developed by the PDP sponsor must contain the required elements for completing an enrollment request as

described in Appendix 2 of this guidance, and must obtain CMS approval following existing marketing material approval procedures prior to use.

Note: For contract year 2011, CMS will require that sponsors include a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g. a confirmation of receipt number).

30.1.4 - Auto- and Facilitated Enrollment

CMS auto and facilitates enrollment of certain LIS beneficiaries into PDPs. “Auto-Enrollment” is the process that refers to full-benefit dual eligibles. “Facilitated Enrollment” is the process that refers to other LIS beneficiaries. The primary differences between the two are the populations and the effective date.

Starting January 1, 2010, CMS will conduct a demonstration in which it contracts with a single PDP sponsor to cover all periods of retroactive auto/facilitated enrollments. This demonstration contractor will be competitively procured. As a result, all auto/facilitated enrollments to qualified PDPs as described below will have prospective effective dates.

A. Populations

1. Auto-Enrollment.

Full-benefit dual eligible individuals who have not elected a Part D plan will be auto-enrolled into one by CMS. Full-benefit dual eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare Part B premiums and/or cost-sharing (sometimes known as QMB-plus or SLMB-plus). CMS will use data provided by State Medicaid Agencies to identify full-benefit dual eligible individuals. Please note that full-benefit dual eligible individuals do not include those eligible *only* for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI).

Full-benefit dual eligible individuals who will be auto-enrolled into a PDP pursuant to this section include those enrolled in:

- Original Medicare;
- A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit;
- An 1876 cost plan that does not offer a Part D optional supplemental benefit;
- Medical Savings Account; *or*
- An 1833 Health Care Prepayment Plan (HC-PP); *and*
- *Who do not meet any of the conditions listed below.*

This excludes full-benefit dual eligible individuals who:

- Live in any of the five U.S. territories
- Live in another country
- Are inmates in a correctional facility
- Have opted out of auto-enrollment into a Part D plan
- Are already enrolled in a Part D plan
 - Note:** Beneficiaries enrolled in a Program of All Inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled
- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan, other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan offered by the same MA organization; please see Section 40.1.5 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2).
- Are enrolled in a *section* 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be auto-enrolled instead into the cost plan's Part D optional supplemental benefit, as is described in Chapter 17, Subpart D, of the Medicare Managed Care Manual).

For modified auto-enrollment procedures for full-benefit dual eligibles for whom employers claim a retiree drug subsidy, please see section 30.1.4.H

2. Facilitated Enrollment

Other LIS eligibles are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e. only eligible for Medicaid payment of Medicare *premiums and/or* cost-sharing); SSI-only (Medicare and *Supplemental Security Income [SSI]*, but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for either the full or partial subsidy. CMS will use data submitted by SSA to identify SSI-only and those who apply for LIS and are determined eligible by SSA. CMS will use data from State Medicaid Agencies to identify those who are QMB-only, SLMB-only, QI, or who apply for LIS and are determined eligible by the State.

Other LIS eligibles who will be enrolled into PDPs pursuant to this section include those enrolled in:

- Original Medicare;
- A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit;
- An 1876 cost plan that does not offer a Part D optional supplemental benefit;
- A Medical Savings Account (MSA); *or*
- An 1833 HCPP; *and*
- Who do not meet any of the conditions listed below.

This excludes other LIS eligibles who:

- Live in any of the five U.S. territories
- Live in another country
- Are individuals for whom the employer is claiming the retiree drug subsidy
- Are inmates in a correctional facility
- Have opted out of facilitated enrollment into a Part D plan
- Are already enrolled in a Part D plan
 - Note:** Beneficiaries enrolled in a Program of All Inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled
- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan *other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan offered by the same MA organization;* please see Section 40.1.5 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2)
- Are enrolled in an 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be facilitated enrolled instead into the cost plan's Part D optional supplemental benefit, *as is described in Chapter 17, Subpart D, of the Medicare Managed Care Manual*).

B. Qualifying PDPs

A PDP qualifies to receive auto/facilitated enrollments in a given region if it meets all the following criteria:

- *offers basic prescription drug coverage*
- *has a premium at or below the low-income premium subsidy amount in the PDP region*
- *meets the “Requirements Critical for Ensuring Effective Enrollment of Dual Eligibles” issued August 31, 2006.*

PDPs that qualify to receive auto/facilitated enrollments may not decline to accept such enrollments. Qualifying PDPs must accept all individuals assigned by CMS who had been previously involuntarily disenrolled by the plan for non-payment of premiums.

Only PDPs with defined standard, actuarially equivalent standard, or basic alternative benefit packages will be included. CMS will not auto/facilitate enroll beneficiaries into PDPs with enhanced alternative benefit packages, even if their premium is at or below the low-income premium subsidy amount for the region. In addition, CMS will not auto/facilitate enroll beneficiaries into an employer-sponsored PDP.

Plans that qualify to receive auto/facilitated enrollments in the current year, but will not in the following year will no longer receive new auto- or facilitated enrollments starting in October of the current year. This avoids the need to immediately reassign these beneficiaries to a different plan.

PDPs that do not qualify in the current year, but do qualify in the following year, will start receiving PDP Notification Files and weekly TRRs with auto/facilitated enrollments starting November of the current year (with effective dates no earlier than January 1 of the following year).

Starting January 1, 2010, only the demonstration contractor will qualify to receive auto/facilitated enrollments for retroactive periods of time. The demonstration contractor will not keep these individuals on a prospective basis.

C. Auto/Facilitated Enrollment Process

CMS performs the auto/facilitated enrollment process each day it receives a source file from a State Medicaid Agency or Social Security Administration. The procedures for auto- and facilitated enrollment into PDPs are identical, and work as follows:

1. CMS will identify full-benefit dual eligible individuals to be auto-enrolled and other LIS eligibles to be facilitated enrolled. CMS uses LIS deemed reason code, which indicates the person was a full benefit dual eligible sometime during the past year, to define those being auto-enrolled. LIS deemed code and LIS applicant data are used to identify those who need to be facilitated enrolled.
2. *CMS will identify PDPs that qualify to receive auto/facilitated enrollments.*
3. CMS will assign beneficiaries to a plan in a two-step process. The first level of assignment is at the PDP sponsoring organization (PDP Sponsor) level. The second level of assignment is to an individual PDP offered by the PDP Sponsor. This will result in approximately the same proportion of auto-enrollees at the PDP Sponsor level.

At the first level of assignment, CMS will identify PDP sponsors that offer at least one *qualifying* PDP in the region. If more than one PDP sponsor in a region meets *this* criteria, CMS will auto/facilitate enroll on a random basis among available PDP sponsors. Please note that if two or more PDP sponsors are owned by the same parent organization, they are treated as a single organization for purposes of this first step of auto/facilitated enrollment.

At the second level of assignment, CMS will identify the *qualifying* PDPs *offered by each sponsor* in the region. If a given PDP sponsor only has one such PDP in the region, all the beneficiaries assigned to the PDP sponsor will be assigned to that one PDP. If the PDP sponsor offers more than one *such* PDP in the region beneficiaries will be randomly assigned *first among the contracts within the sponsoring organization (if there are more than one with a qualifying PDP), and then among the qualifying PDPs a contract offers.*

This method of random enrollment will result in full-benefit dual eligibles and other LIS beneficiaries being assigned in approximately equal proportions among available PDP sponsors, not PDPs. Since PDP sponsors may offer different numbers of PDPs that meet the auto/facilitated enrollment criteria, auto/facilitated enrollment proportions may vary at the PDP level.

EXAMPLE:

There are 4 PDP-sponsoring organizations in a region that offer one or more plans with premiums at or below the low income premium subsidy amount. The numbers of PDPs with an appropriate premium are as follows:

Organization A—1 PDP
Organization B—1 PDP
Organization C—2 PDPs
Organization D—3 PDPs

Step 1: The auto/facilitated enrollment population would first be divided equally and randomly among the four PDP sponsors. Thus, each PDP sponsor would be assigned 25 percent of the available population.

Step 2: Within each PDP sponsor, the population would again be divided equally and randomly. Thus, all of Organization A's enrollees would be assigned to its one appropriate PDP; the same would be true for Organization B; 50 percent of the population assigned to Organization C would be assigned randomly to each of its two plans; and 33.3 percent of the population assigned to Organization D would be assigned randomly to each of its three plans.

PDPs with premiums below the low-income subsidy amount will not be treated more favorably than those with premiums equal to the low-income premium subsidy amount. A PDP's other beneficiary charges – copayment levels, deductibles, etc. – will not be a factor in determining whether it qualifies for auto/facilitated enrollment provided the PDP offers basic prescription drug coverage.

4. CMS will *calculate the effective date as the first day of the second month after the current month (see section 30.1.4.D below for details)*, create a *code 61* enrollment transaction for each auto and facilitated *enrollment, and submit it to the MARx system.*
5. Immediately after auto/facilitated enrollment occurs, the PDP will receive the preliminary “PDP notification file” identifying those assigned, *including* addresses and full names. *CMS does not maintain phone number data on beneficiaries, so this information cannot be transmitted to PDP sponsors.* This *file* ensures PDPs are notified *of new auto/facilitated enrollees* prior to beneficiaries receiving CMS' auto/facilitated enrollment notice. *Since*

auto/facilitated enrollment can occur daily, these files may be transmitted as frequently as daily.

6. The PDP will then be notified via the weekly TRR of the auto/facilitated enrollment confirmed processed by MARx, including the effective date.

For technical specifications and file formats, please see sections 8.2 and E.2 of the Plan Communications User Guide, on the CMS website at http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp.

D. Effective Date

Starting January 1, 2010, all auto/facilitated enrollments generated by CMS into qualifying PDPs will have prospective effective dates. Specifically, the effective date will be the first day of the second month after CMS identifies the person.

***Example:** Throughout 2010, an individual is eligible for Part D. On July 14, 2010, the State sends data to CMS identifying the person as a full or partial dual, or SSA sends data to CMS identifying the person as a new SSI-only or LIS applicant, retroactive to March 1, 2010. CMS randomly auto/facilitate enrolls the person into a qualifying PDP effective September 1, 2010. If the person was a full dual or SSI-only, CMS creates a second auto/facilitated enrollment transaction into the demonstration contractor for March 1 – August 31, 2010.*

CMS will calculate the auto/facilitated enrollment effective date, which will be conveyed to plans in the PDP Notification File and the weekly TRR. CMS will ensure that any beneficiary choice will “trump” facilitated enrollment by creating an artificially early application receipt date for systems processing purposes.

For retroactive periods, CMS will auto/facilitate enroll full-benefit dual eligibles and SSI-only beneficiaries into the demonstration contractor. Please see below for details on when retroactive periods of coverage are necessary and how they are calculated.

1. Retroactive Auto/Facilitated Enrollments for Full Duals and SSI-Only

Full-benefit dual eligibles and SSI-only beneficiaries may qualify to be retroactively auto/facilitated enrolled by CMS into the demonstration contractor. Partial dual eligibles and LIS applicants do not qualify for retroactive assignments.

For full-benefit dual eligible individuals who are Medicaid eligible first and then subsequently become Medicare eligible, the effective date of auto-enrollment will be the first day of Part D eligibility. This effective date ensures there is no coverage gap between the end of Medicaid prescription drug coverage and the start of Medicare prescription drug coverage. CMS will make every effort to identify these individuals prior to the start of their Part D eligibility, so that we can notify beneficiaries and plans prospectively of auto-enrollment. However, in cases where we cannot do so, the

enrollment may be retroactive. Please note that Part D eligibility always falls on the first day of the relevant month.

Example: An individual has Medicaid coverage throughout **2010**. *On March 15, 2010, the State sends data identifying the person as a prospective full dual who will become Medicare Part D eligible in May, 2010. That night, CMS randomly autoenrolls the person into a qualifying PDP effective May 1, 2010.* The last day of eligibility for Medicaid prescription drug coverage is April 30, **2010**.

Retroactive eligibility for Medicare Parts A and/or B will not result in retroactive effective dates for auto-enrollment. This is because Medicare Part D eligibility cannot be retroactive. If eligibility for Part A and/or B is retroactive, Part D eligibility is effective the first day of the month in which the beneficiary received notification of retroactive Medicare Part A/B entitlement (see §10).

Example: An individual has Medicaid coverage throughout **2010**. In May **2010**, the individual is notified that s/he is entitled to Medicare Part A and/or B retroactive to November, **2009**. The last day of eligibility for Medicaid prescription drug coverage is April 30, **2010**; the first day of Part D eligibility is May 1, **2010**. *The person is included on a state MMA file on May 20; CMS autoenrolls the beneficiary into the demonstration contractor for May 1 through June 30, 2010; and randomly autoenrolls into a qualifying PDP effective July 1, 2010.*

For those who are Medicare eligible first, and then subsequently become Medicaid eligible, auto-enrollment will be effective the first day of the month the person became Medicaid eligible (i.e. achieved full-benefit dual status), or January 1, 2006, whichever is later. For this population, there is no data that can be used to identify them prospectively, so the effective date will likely always be retroactive. Please note that auto-enrollment will only occur if the beneficiary is not already enrolled in a Part D plan; if the person is already in a Part D plan, the only impact of becoming newly eligible for Medicaid is that the individual will be deemed eligible for the full low-income subsidy.

Example: An individual is Medicare Part **D eligible through 2010**. *The person applies for Medicaid in August 2010, is determined in October, 2010 to be Medicaid-eligible back to August 1, 2010, and is included on a state MMA file in October.* Because the person has Medicare, she/he is not eligible for Medicaid prescription drug coverage (note she/he remains eligible for other Medicaid benefits). CMS autoenrolls the beneficiary *into the demonstration contractor* retroactive to August 1, **2010, and randomly into a qualifying PDP effective December 1, 2010.**

Example: An individual becomes Medicare Part D eligible in May **2010**. That same month, the individual applies for Medicaid. In August **2010**, the State Medicaid Agency awards Medicaid eligibility effective February 1, **2010** (Medicaid eligibility may be retroactive to three months before the month of application), *and includes the person on a state MMA file in August*. In this scenario, Medicaid prescription drug coverage is effective February 1 – April 30, **2010**. CMS *auto-enrolls the beneficiary into the demonstration contractor* retroactive to May 1, **2010, and randomly autoenrolls the person into a qualifying PDP effective October 1, 2010.**

CMS will auto-enroll full-benefit dual eligibles who have disenrolled, either voluntarily or involuntarily, from a Part D plan and failed to enroll in a new plan (unless they affirmatively declined or opted-out of auto-enrollment). The effective date will be retroactive to the month after the disenrollment effective date of the previous Part D plan enrollment.

Example: A full-benefit dual eligible *or SSI-only eligible* disenrolls from a Part D plan (either voluntarily or involuntarily), effective March 31, **2010**. In the April auto/*facilitated* enrollment run, CMS *auto/facilitate enrolls the person into the demonstration contractor effective April 1, and randomly into a qualifying PDP effective June 1, 2010.*

In limited instances, a full-benefit dual eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled, or CMS auto/facilitates enrollment of a beneficiary with a given effective date, but subsequently data become available that show the effective date should have been earlier. Individuals with active elections in a Part D plan are not included in CMS' auto-enrollment process, so the auto-enrollment process does not create an enrollment for the uncovered month(s). *In these instances, the beneficiary contacts the demonstration contractor to request coverage for the uncovered month(s) in the past.*

The PDP must move up the effective date of a facilitated enrollment by a month if the LIS beneficiary requests this in a timely fashion, i.e. before the start of the earlier month. The *PDP must accept these requests verbally and in writing; it cannot limit such request to written requests.* The beneficiary can contact the plan by telephone or in writing to make this request. If the person is a partial dual eligible, the SEP under section 20.3.2 should be used. If the person is an SSI-only eligible or an individual who applied and was determined eligible for LIS by SSA or a State Medicaid Agency, the SEP under section 20.3.8 #7 is available.

Example: CMS facilitates enrollment of an Other LIS eligible in May, **2010**, effective July 1, **2010**. The beneficiary receives the facilitated enrollment notice in May, and by May 31 requests the PDP makes the facilitated enrollment effective June 1. The PDP submits an enrollment transaction to do so.

E. CMS Notice Provided to Auto/Facilitated Enrolled Beneficiaries:

CMS will notify the beneficiary that she/he will be auto/facilitated enrolled in a given PDP on the auto/facilitated enrollment effective date unless s/he chooses another Part D plan (either another PDP, or an MA-PD plan, a PACE organization, or an 1876 cost plan that offers a Part D optional supplemental benefit), or opts out of auto/facilitated enrollment into a Part D plan altogether. *For beneficiaries who have a retroactive period of auto/facilitated enrollment, the notice will provide information on obtaining coverage for those periods through the demonstration contractor. Auto-enrollment notices will be on yellow paper; facilitated notices will be on green paper.* If the beneficiary does not take either action, the person's silence will be deemed consent with the auto/facilitated

enrollment, and it will take effect on the effective date. Additionally, all LIS and dual eligible individuals have a Special Enrollment Period (SEP) that permits them to change Part D plans at any time, even after the auto/facilitated enrollment takes effect (refer to section 20.3.2 *and* 20.3.8.7 of this guidance).

CMS has created an exception to the auto-enrollment procedures for full benefit dual eligible individuals who CMS knows to be enrolled in a qualifying employer group plan and for whom CMS has approved the group health plan sponsor to receive the Retiree Drug Subsidy (RDS) (see section 30.1.4.H). CMS will provide notice to such individuals of their choices and advise them to discuss the potential impact of Medicare Part D coverage on their group health plan coverage. This notice informs such individuals that they will be deemed to have declined to enroll in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm that they wish to be auto-enrolled in a PDP. Individuals who elect not to be auto-enrolled, may enroll in Medicare Part D at a later time if they choose to do so.

F. PDP Notice and Information Provided to Auto/Facilitated Enrolled Beneficiaries:

PDPs must send a notice confirming the auto-enrollment (see Exhibit 24) or facilitated notice (see Exhibit 25) within 10 calendar days after receiving CMS confirmation of the enrollment from the *weekly* TRR or the *PDP Notification File* with addresses of auto/*facilitated* enrollees, whichever is later.

PDPs must also send a modified version of the pre- and post-enrollment materials that must be provided to those who voluntarily enroll in a PDP. If the address indicates the beneficiary is outside the PDP region, please follow procedures in section 40.2.1.4.

Prior to the effective date, the PDP must send each individual who has been auto/facilitated enrolled:

- Proof of health insurance coverage so that he/she may begin using the plan services as of the effective date;

NOTE: This is not the same as the Evidence of Coverage document described in CMS' marketing guidelines. This evidence may be in the form of member cards, the enrollment form, and/or a notice to the member. If the PDP sponsor does not provide the member card prior to the effective date, it must provide it as soon as possible after the effective date.

- The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts (including general information about the low income subsidy);
- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card); AND

- A Summary of Benefits *or Evidence of Coverage*. Those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto-enrolled or change to another one that better meets their needs. Providing the Summary of Benefits *or Evidence of Coverage*, which is generally considered pre-enrollment marketing material, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

The requirement in §30.4.2 to inform the beneficiary of whether the enrollment was accepted or rejected does not apply to auto/facilitated enrollments, since CMS generates these transactions and they are already confirmed at the point when the sponsor is notified via the TRR.

There may be certain times during the month death information is updated in CMS records after the auto-assignment/enrollment process has occurred, resulting in auto-enrollment of individuals with a deceased code. In cases where the PDP sponsor receives an auto-enrollment with a deceased code, the PDP sponsor must send a notice to the estate of the member (see Exhibit 13a).

PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto or facilitated enrolled; they only need to conduct the annual survey.

G. Opt Out:

Full-benefit dual eligible and other LIS eligible individuals may opt out of (affirmatively decline) auto/facilitated enrollment into a Part D plan. The primary means for doing so is by calling 1-800-MEDICARE. However, the beneficiary may also call the PDP into which he/she has been auto/facilitated enrolled. The entity contacted by the beneficiary must inform the individual of the implications of his/her request. In addition, a follow-up notice must be provided that confirms the request to opt-out, and explains the consequences (see Exhibit 26). The entity then sends a Code 51 disenrollment transaction and sets the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment).

The beneficiary may opt-out either prior to the auto/facilitated enrollment effective date, or once enrolled in a Part D plan (whether voluntarily or auto/facilitated enrolled into it). If the beneficiary makes the request prior to the effective date of auto/facilitated enrollment, then the entity receiving the opt-out request will submit a disenrollment transaction (with specific coding indicating that the transaction is an opt-out). will cancel the auto/facilitated enrollment, and the person will never be enrolled. *The MA organization should then send the model notice in Exhibit 26. This* If the beneficiary makes the request *after the effective date of enrollment* in the plan, then the request results in a disenrollment effective the last day of the month in which the request was made, *and the model notice in Exhibit 26a should be used.*

Please note that an individual who opts-out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto/facilitated enrollment processes.

If the beneficiary decides she/he wants to obtain the Part D benefit in the future, she/he does so simply by enrolling in a new plan. LIS eligible individuals have a Special Enrollment Period, so they can enroll at anytime; they are not limited to the AEP. The enrollment request will be effective the first of the month following the month in which the Part D plan receives the enrollment request.

H. Special Procedures for Full Benefit Dual Eligibles with Retiree Drug Subsidy

CMS has created an exception to the auto-enrollment process for full-benefit dual eligible individuals who are qualifying covered retirees and for whom CMS has approved the group health plan sponsor to receive the Retiree Drug Subsidy (RDS). The exception process includes:

- *CMS identifies the full-benefit dual eligible individuals with RDS and excludes them from automatic enrollment in a Part D plan; and*
- *CMS sends a notice (see section 30.1.4.E) to these individuals*
 - *Informing them of their choices and that they need to proactively enroll in a Part D plan, if they wish to do so;*
 - *Suggesting that these individuals discuss the potential impact of their decision, on both drug and medical retiree benefits for themselves and their families, with the appropriate staff of the qualified retiree prescription drug plan; and*
 - *Indicating that they will be deemed to decline enrollment in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm they wish to be auto-enrolled into a Part D plan.*

30.1.5 - Re-Assignment of Certain LIS Beneficiaries

CMS has the discretion to re-assign LIS beneficiaries, including situations in which their current plan will have a premium above the low-income premium subsidy amount (i.e., benchmark) in the following year. CMS will announce its intent to conduct reassignment in the Call Letter. CMS will conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified. Affected PDPs are not responsible for initiating any enrollment or disenrollment transactions for reassigned beneficiaries, except for re-enrollment of beneficiaries who opt to remain in their current plan, as described below. Affected PDPs are only responsible for responding to the CMS enrollment transaction promptly when they receive it and for providing appropriate beneficiary notices and materials, also as described below.

A. Population to be Re-Assigned

CMS will reassign beneficiaries *enrolled in “Losing” PDPs* who meet all of the following criteria:

For PDPs that *offered a basic benefit and premium below the regional LIS benchmark in the current year, but will lose to reassign because they will* have a premium in the following year that will be above the benchmark amount or are converting to an enhanced benefit:

- They will continue to be eligible for 100% premium subsidy LIS in *the following year*.
 - *Individuals may qualify for 100% premium subsidy because they were deemed eligible for LIS (i.e., because they were a full benefit dual eligible, Medicare Savings Program participant, or Supplemental Security Income (SSI) recipient), OR because they applied and were found eligible for the 100% LIS premium subsidy.*
- They were originally *enrolled by CMS* into their current *PDP, i.e. through auto/facilitated enrollment, or reassignment.*
- They did not voluntarily elect another plan.
- They do not live in a U.S. territory.

For PDPs that are non-renewing (terminating):

- All current LIS enrollees who will continue to have LIS in the following year, regardless of premium subsidy amount, and regardless of whether the individual was assigned to or voluntarily enrolled in a plan.

Beneficiaries enrolled in a Medicare Advantage plan or a PACE organization are not reassigned, regardless of change in the Part D premium or benefit package.

The actual reassignment process is typically run on a single day in early October. CMS will only reassign beneficiaries who meet the above criteria as of the day of the reassignment run. CMS does not subsequently “sweep” for individuals who may meet the criteria at later points in time.

B. “Losing” PDPs

A PDP will lose LIS beneficiaries to re-assignment if it meets either of the following criteria:

- *The PDP has beneficiaries originally auto/facilitated enrolled or reassigned by CMS and there will be a new premium liability in the following year for those eligible for 100% premium subsidy under LIS. This includes premium increase due to premium going above the benchmark or converting to an enhanced benefit package*

- *The PDP is terminating for the following year.*

As part of determining whether a terminating PDP should be included in reassignment, CMS determines whether it is truly non-renewing (i.e. all beneficiaries will be disenrolled with no automated enrollment into another PDP), or whether beneficiaries are actually being cross-walked to a different PDP. If the latter, CMS will perform the following additional steps:

- *Determine if the PDP had a premium below the LIS regional benchmark and a basic benefit in the current year, and has beneficiaries who have been auto/facilitated enrolled by, or received previously as reassignees from, CMS*
 - *If it does not, then the PDP will be carved out of reassignment (i.e. not considered “terminating” for purposes of reassignment), and all beneficiaries will be cross-walked.*
 - *If it does, CMS will determine whether the PDP to which beneficiaries are cross-walked qualify as a “Gaining” PDP per section 30.1.5.G.*
 - *If so, the beneficiaries will not be included in reassignment, and all beneficiaries will be cross-walked, since the plan to which they are being cross-walked will have no premium for those with 100% premium liability.*
 - *If not, beneficiaries who meet the criteria for reassignment due to premium increase in section 30.1.5.A above will be reassigned (to ensure they have no new premium liability the following year); the remaining beneficiaries will be cross-walked.*

CMS account managers will contact losing plans in September to confirm the plan is aware it will lose beneficiaries due to reassignment. Plans that are uncertain about whether they will lose to reassignment or not should contact their account manager to confirm.

C. Re-assignment Process

*CMS will attempt to reassign beneficiaries within the same organization wherever possible. First, CMS will identify other **qualifying plans** in the same region offered under the same contract number, or if that is not available, under a different contract number sponsored by the same parent organization. If the organization has more than one such plan in that region, CMS will randomly reassign beneficiaries among those plans.*

*If the organization does NOT offer another **qualifying PDP**, CMS will randomly reassign affected beneficiaries to other PDP sponsors that have at least one **qualifying PDP** in that region. CMS will follow the two-step process used under auto/facilitated enrollment, i.e. random distribution first at the sponsor level, then randomly among qualifying plans within the sponsor (see section 30.1.4.C).*

Reassignment usually takes place in early October. CMS will send a preliminary file of reassignees to “gaining” and “losing” plans in mid-October. This file shall be used by plans for purposes of identifying beneficiaries who will be receiving CMS’ blue reassignment letters; for “gaining” plans to obtain full name and address data; and for “losing” plans to identify the appropriate ANOC per section 30.1.5.E. The final confirmation will be received via weekly TRR in late November.

Please note: beneficiaries are not always assigned to a “gaining” PDP that serves the same region as the “losing” PDP. CMS will use the beneficiary’s state of residence to determine where the beneficiary needs to be reassigned. CMS determines state of residence first by checking if a state submitted the person on a recent state MMA file; if the person was not included on a recent state MMA file, CMS then uses the beneficiary address on its system. It is possible that, since originally assigned to a plan, a beneficiary’s address had changed, so s/he must be reassigned to a new region. As a result, when reassignment is to another plan within the same organization, sponsors may not see all beneficiaries from the “losing” plan moved to the “gaining” plan. In addition, PDPs in regions with no “losing” plans may gain a few beneficiaries from reassignment.

Finally, “gaining” plans may receive reassignees that appear to reside outside the region (based on beneficiary address), but who are not. For these individuals, sponsors should follow the procedures in section 40.2.1.4.

D. CMS Notification to Beneficiaries

CMS will ensure that all beneficiaries being re-assigned are notified. These notices *will be on blue paper, and* will instruct beneficiaries who are being reassigned because of a premium increase to contact their current plan if they wish to remain with the plan for the following year.

E. Plan Communication to Affected Beneficiaries

“Losing” PDPs are responsible for sending an appropriate ANOC, *as follows:*

- *If individuals are being reassigned within the same organization, the ANOC should be for the following year’s plan, and include the Evidence of Coverage and LIS Rider.*
- *If the PDP is losing beneficiaries to a different PDP sponsoring organization, it may, at its discretion, use the alternate ANOC in Exhibit 30; it need not send the Evidence of Coverage or LIS Rider.*
 - *If it chooses to use the standard ANOC, it should use the version applicable to the plan in which the beneficiary is currently enrolled, and shall include the Evidence of Coverage and LIS Rider.*

“Losing” PDPs should make their best effort to identify individuals who will be lost to reassignment for purposes of providing the appropriate ANOC. CMS sends a preliminary file of reassignees to “losing” PDPs in September for this purpose. In

addition, plans may identify potential reassignees by identifying those that meet both of the following conditions:

Individuals initially assigned by CMS (enrollment source = A [auto-enrollment], C [facilitated enrollment] or H [reassignment]; or TRCs 117, 118, or 212A)

and

Individual has 100% premium subsidy in following year (per the TRR or monthly LIS history report)

Terminating PDPs should send a termination notice as instructed in the Call Letter.

Additionally, “losing” plans will be required to send a letter confirming disenrollment from the plan due to re-assignment *within 10 calendar days from receiving disenrollment confirmation on a weekly TRR* (See Exhibit 10(b) for model letter).

“Gaining” PDPs are responsible for providing enrollment confirmation (See Exhibit 29) and enrollment materials to beneficiaries *within 10 calendar days of receiving confirmation of reassignment on a weekly TRR*.

“Gaining” PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto or facilitated enrolled; they only need to conduct the annual survey.

F. Requests for “Re-Enrollment” in the “Losing” Plan

CMS’ notices to affected beneficiaries will instruct them to contact their current plan if they wish to remain with the plan for the following year. If a reassigned beneficiary contacts the plan and indicates that s/he wishes to remain enrolled despite incurring premium liability, **the plan must take a new enrollment election** in accordance with §30.1.1 – 30.1.3 and §30.2 f. *For the new enrollment, use the actual application date, which should be no earlier than November 15 of the current year; an election type of “S” (Special Enrollment Period), and an effective date of January 1 of the following year.*

As part of this enrollment, the plan must confirm and document the beneficiary’s understanding of the financial liability s/he will incur by remaining with the plan for the following year. **However, DO NOT transmit these enrollment elections to CMS until a TRR is received confirming the beneficiary’s disenrollment from the plan in late November.** *If the “re-enrollment” transaction is sent in before disenrollment due to reassignment is confirmed, the transaction will be rejected as “beneficiary already enrolled.” For beneficiaries re-enrolling in their current plan, the sponsor need not send a disenrollment confirmation letter, but must send the standard enrollment confirmation letter in section 30.4.*

G. “Gaining” PDPs

PDPs that qualify for auto- and facilitated enrollment (*see section 30.1.4.B*) with effective dates starting January 1 of the following year will also qualify to receive those LIS beneficiaries reassigned as described above. Qualifying PDPs must meet the “Requirements Critical for Ensuring Effective Enrollment of Dual Eligibles” issued August 31, 2006.

30.1.6 - Group Enrollment Mechanism for Employer/Union Sponsored PDPs

CMS will allow an employer or union group to enroll its retirees using a group enrollment process that includes providing CMS with any information it has on other insurance coverage for the purposes of coordination of benefits, as well as creditable coverage history it has on each beneficiary group enrolled for purposes of assessing the late enrollment penalty.

It is the PDP sponsor’s responsibility to ensure the group enrollment process meets all applicable PDP enrollment requirements. PDP sponsors must ensure that any contracts and/or other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.

The group enrollment process must include notification and materials to each beneficiary as follows:

- Beneficiaries participate in the group enrollment mechanism by receiving advance notice that the employer/union intends to enroll them for a prospective date in a PDP that the employer/union is offering; and
- That the beneficiary may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to employer/union benefits opting out would bring; and
- This notice must be provided not less than 21 calendar days prior to the effective date of the beneficiary’s enrollment in the group sponsored PDP.
- Additionally, the notification materials provided must include a summary of benefits offered under the employer/union sponsored PDP, an explanation of how to get more information about the PDP, and an explanation on how to contact Medicare for information on other Part D options that might be available to the beneficiaries. Each individual must also receive the information contained on page 3 of Exhibit 1 of this guidance

For enrollment processing purposes, the application date is the first day of the month prior to the effective date of the group enrollment for all mechanisms at all times. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems. For the purposes of providing notices and meeting other timeframe requirements, PDP sponsors will use the date the organization receives the request. For example, if a valid group enrollment mechanism file is received by the organization on January 24th for enrollments effective February 1st, the receipt date

for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.

The employer/group or union must provide all the information required for the PDP sponsor to submit a complete enrollment request transaction to CMS as described in this and other CMS Part D systems guidance. Refer to Appendix 2.

30.1.7 - Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow qualified SPAPs to submit enrollment requests in an agreed-upon electronic file format to PDPs in accordance with the following provisions:

- The SPAP must attest, as required by section 30.2.1 of this guidance that it has the authority under state law to enroll on behalf of its members.
- The SPAP must coordinate with the PDP to provide the required data elements for the plan to process and submit an enrollment request to CMS.
- The SPAP must provide a notice to its members in advance of submitting the requests for a prospective date that explains that the SPAP is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, PDPs that agree to accept enrollment requests from SPAPs in this format are required to process them like any other enrollment and in accordance with notification timeframes. It is important for the PDP sponsor to work with the contact at the SPAP in the event that the plan encounters any problems processing the enrollment request in the format provided. Because the SPAP is the authorized representative of the beneficiary, the plan is responsible for following up with the SPAP if the enrollment is incomplete in any way (to obtain missing information) or if the enrollment is conditionally rejected due to the existence of the employer/union drug coverage (to confirm that the individual understands the implications of enrolling in a Part D plan).

Special note for SPAP enrollment requests during the AEP - For enrollment processing purposes, the application date on the enrollment transaction submitted to CMS must be set to November 15th with the effective date of January 1st and the election period identifier of “A” (for AEP). This will ensure that subsequent beneficiary-generated enrollment requests made during the AEP will supersede the SPAP enrollment in CMS systems.

30.2 - Processing the Enrollment Request

If an enrollment request is completed during a face-to-face interview, the PDP sponsor should use the individual’s Medicare card to verify the spelling of the name, and to confirm the correct recording of sex, Health Insurance Claim Number, and dates of entitlement to Medicare Part A and/or enrollment in Part B. If the form is mailed or faxed to the PDP sponsor, or for on-line or other enrollment processes, the PDP sponsor

should verify this information with the individual via telephone or other means, or request that the individual include a copy of his/her Medicare card when mailing in the enrollment request. Regardless of whether or not the sponsor has reviewed the Medicare Identification card, the sponsor must still validate and verify Medicare entitlement as described in item “B” below in this section.

Appendix 2 lists all the elements that must be provided in order to consider the enrollment request complete. If the PDP sponsor receives an enrollment request that contains all these elements, the PDP sponsor must consider the enrollment request complete even if all other data elements on the enrollment request are not filled out. If a PDP sponsor has received CMS approval for an enrollment request vehicle that contains data elements in addition to those on the model paper enrollment form included in this guidance, then the enrollment request must be considered complete even if those additional elements are not filled in.

If a PDP sponsor receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. Instead, the enrollment is considered incomplete and the PDP sponsor must follow the procedures outlined in §30.2.2 in order to complete the enrollment. The PDP sponsor must check available CMS systems (e.g. either the BEQ or MARx online query – M232 screen) for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the “sex” field on the enrollment, the PDP sponsor could obtain this information via available systems rather than request the information from the beneficiary.

The following should also be considered when completing an enrollment:

- A. Permanent Residence Information** - The PDP sponsor must obtain the individual’s permanent residence address to determine that he/she resides within the PDP plan’s service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the PDP sponsor must consider the enrollment election incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the PDP sponsor should consult the State law in which the PDP sponsor operates and determine whether the enrollee is considered a resident of the State.
- B. Entitlement Information** – Following the procedures outlined in the CMS Plan Communications User Guide, PDP sponsors must verify Part D eligibility/Medicare entitlement by either the Batch Eligibility Query (BEQ) process or the MARx online query (M232 screen) for all enrollment requests except enrollment requests from a current enrollee of a PDP who is requesting enrollment into another PDP offered in the same contract (i.e. S#) with no break in coverage (i.e. “switching plans”).

Individuals are not required to provide evidence of entitlement to Medicare Part A and/or enrollment in Part B with their enrollment request. If the systems (BEQ or MARx on-line query) indicate that the individual is entitled to Medicare Part A and/or enrolled in Part B, then no further documentation of Medicare entitlement from the individual is needed.

When neither the BEQ, the MARx online query (M232 screen), or MAPDIUI beneficiary eligibility query show Medicare eligibility for Part D, the PDP organization must consider the individual's Medicare ID card to be evidence of Medicare entitlement. When neither BEQ/MARx query nor the Medicare ID card is available, the sponsor must consider an SSA award letter that shows Medicare entitlement (including start dates) as evidence of Medicare entitlement.

If the PDP sponsor is not able to verify entitlement as described above, refer to §30.2.3 for additional procedures.

- C. Effective Date of Coverage** - The PDP sponsor must determine the effective date of enrollment as described in §20.4 for all enrollment requests. If the individual fills out an enrollment request in a face-to-face interview or through telephone enrollment, then the PDP sponsor representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the PDP sponsor to confirm the actual effective date of enrollment. The PDP sponsor must notify the member of the effective date of enrollment prior to the effective date (refer to §30.4 for more information and a description of exceptions to this rule).

If an individual submits an enrollment request with an unallowable effective date, or if the PDP sponsor allowed the individual to select an unallowable effective date, the PDP sponsor must notify the individual in a timely manner and explain that the enrollment must be processed with a different (allowable) effective date of enrollment. The organization should resolve the issue with the individual as to the correct effective date, and the notification must be documented. If the individual refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the enrollment according to the procedures outlined in §50.1.

PDP sponsors must ensure enrollees have access to plan benefits as of the effective date of enrollment the PDP sponsor has determined and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS systems.

For auto/facilitated enrollments, refer to section §30.1.4 of this guidance for more information.

- D. Health Related Information** - PDP sponsors may not ask health screening questions during the enrollment process.

- E. Statement of Understanding and Release of Information -** The PDP sponsor must include the information contained in **Exhibit 1** on page 3 under the heading “Please read and sign below” in all of its enrollment request vehicles.

Special Note for Part D Payment Demonstrations Plans Only:

Employer or union groups are prohibited from making payments of any kind on behalf of an individual enrolling in a Part D payment demonstration plan. Each new individual enrolling in such a plan will be required to provide an attestation regarding employer or union group payment. PDP sponsors must include the following attestation statement along with the other required “statements of understanding” in all enrollment requests vehicles (e.g. the enrollment form) for individuals joining a Part D Payment Demonstration PDP:

“By joining this plan, I attest that I am not receiving any financial support from my current or former employer or union group (or my spouse's current or former employer/union group) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage health plan or Medicare drug plan.”

- F. Signature and Date on Paper Enrollment Forms -** When a paper enrollment form is used, the individual must sign the enrollment form. If the individual is unable to sign the form, a legal representative must sign the enrollment form (refer to §30.2.1 for more information). If a legal representative signs the form for the individual, then he or she must attest on the form that he or she has the authority under State law to effect the enrollment request on behalf of the individual and that a copy of the proof of other authorization required by State law that empowers the individual to effect an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Acceptable documentation includes items such as court-appointed legal guardianship or durable power of attorney.

The individual and/or legal representative should also write the date he/she signed the enrollment request; however, if he/she inadvertently fails to include the date on a paper enrollment form, or if an alternate enrollment mechanism is used, then the date of receipt that the PDP sponsor notes on the enrollment request will serve as the “signature date” of the request.

If a paper enrollment form is submitted and the signature is not included, the PDP sponsor may verify with the individual with a phone call and document the contact, rather than return the paper enrollment form as incomplete. The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).

When an enrollment request mechanism other than paper is used, the individual or his or her legal representative must complete the enrollment mechanism process, including the attestation of legal representative status as described above. A pen-and-ink signature is not required.

G. Other Signatures - If the PDP sponsor representative helps the individual fill out the enrollment request, then the PDP sponsor representative must also sign the enrollment form and indicate his/her relationship to the individual. However, the PDP sponsor representative does not have to co-sign the form when:

- He/she pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to him/her,
- He/she fills in the "office use only" block, and/or
- He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

The PDP sponsor representative does have to co-sign the form if he/she pre-fills any other information, including the individual's phone number.

H. Old Enrollment Requests- If the PDP sponsor receives an enrollment request that was completed more than 30 calendar days prior to the PDP sponsor's receipt of the request, the PDP sponsor is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

I. Determining the Application Date- The application date is the date the enrollment request is received by the PDP sponsor, except for CMS On-line Enrollment Center requests, requests made into employer or union-sponsored plans, and auto or facilitated enrollments. If the request received is incomplete, follow the instructions provided in section 30.2.2 below.

The PDP sponsor must date as received all enrollment requests as soon as they are initially received by the PDP sponsor, as follows:

- For requests sent by mail, the application date is the date the application is received by the plan (*postmark is irrelevant*).
- For requests received by fax, the application date is the date the application is received on plan's fax machine.
- For requests made to/submitted to sales agents, including brokers, the application date is the date the agent/broker receives (accepts) the enrollment request and not the date the organization receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed or contracting with the plan, is considered received by the plan, thus all CMS required timeframes for enrollment processing begin on this date.

- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and has been recorded.
- For requests made via the Medicare.gov Online Enrollment Center (OEC), the application date is the date CMS “stamps” on the enrollment request at the time the individual completed the OEC process. This is true regardless of when a plan ultimately retrieves or downloads the request.
- For internet enrollment requests made directly to the plan’s website, the application date is the date the request is completed through the plan’s website process. This is true regardless of when a plan ultimately retrieves or downloads the request.
- For all enrollment requests into employer or union sponsored PDPs, including via group enrollment mechanisms, as described in §30.1.6, the application date will be first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems.
- For auto- or facilitated enrollment, as described in §30.1.4, the application date is first day of the month prior to the effective date of the auto/facilitated enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.

Part D plans must use the application date in the appropriate field when submitting enrollment transactions to CMS. Appendix 3 of this guidance provides a summary of application dates for CMS enrollment transactions.

J. Correction of Information - The PDP sponsor may find that it must make corrections to an individual’s enrollment request. For example, an individual may have made an error in writing his or her telephone number or may have transposed a digit in his or her date of birth. The PDP sponsor should make this type of correction to the enrollment request (e.g. the enrollment form) when necessary, and the individual making those corrections should place his/her initials and the date next to the corrections. A separate “correction” sheet, signed and dated by the individual making the correction, or an electronic record of a similar nature, may be used by the PDP sponsor (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the PDP sponsor having to co-sign the enrollment form.

K. Sending the Enrollment to CMS – For all complete enrollment requests, the PDP sponsor must transmit the appropriate enrollment transaction to CMS within the time frames prescribed in §30.3, and must send the individual the information described in §30.4 within the required time frames. Processes for submitting transactions are provided in CMS systems guidance.

L. Premium Payment and Withhold options

At minimum, PDP sponsors must include on all enrollment request mechanisms the option for individuals to: 1) pay plan premiums by being billed directly by the plan or 2) have the premiums withheld from their SSA benefit check. The plan may also choose to offer other payment methods, such as automatic deduction from the individual's bank or other financial institution or from a credit card.

The enrollment mechanism must advise the individual that if s/he does not select a premium payment option, the default action will be direct bill.

On the enrollment mechanism, PDP sponsors must also include in this section a statement that advises those individuals who qualify for extra help that if the extra help does not cover the entire plan premium, the individual is responsible for the amount that Medicare does not cover.

Model language has been provided on Exhibits 1 and 1b to reflect the required options.

Note: At this time, neither RRB nor OPM is able to process withhold requests.

30.2.1 - Who May Complete an Enrollment Request

A Medicare beneficiary is generally the only individual who may execute a valid enrollment request in, or disenrollment request from, a PDP. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the State in which the beneficiary resides may allow. CMS will recognize State laws that authorize persons to effect a Part D enrollment or disenrollment request for Medicare beneficiaries. Persons authorized under State law may include court-appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, PDP sponsors should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

When someone other than the Medicare beneficiary completes an enrollment request, he or she must:

- 1) Attest that he or she has the authority under State law to make the enrollment request on behalf of the individual;

- 2) Attest that proof of authorization, if any, required by State law that empowers the individual to effectuate an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Part D sponsors cannot require such documentation as a condition of enrollment; and
- 3) Provide contact information.

When an authorized representative completes an enrollment request on behalf of a beneficiary, the PDP sponsor should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes.

Representative payee status, as designated by SSA, is not necessarily sufficient to enroll or disenroll a Medicare beneficiary. Where PDP sponsors are aware that an individual has a representative payee designated by SSA to handle the individual's finances, PDP sponsors should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/she is the appropriate person, under State law, to execute the enrollment or disenrollment request.

30.2.2 - When the Enrollment Request Is Incomplete

When the enrollment request is incomplete, the PDP sponsor must document its efforts to obtain the missing information or documentation needed to complete the enrollment request. The sponsor must make this determination and notify the individual within 10 calendar days of the receipt of the request that additional documentation is needed for the enrollment request.

For AEP elections, additional documentation to make the request complete must be received by December 31, or within 21 calendar days (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days (whichever is later).

When an incomplete enrollment request is received near the end of a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission "cut-off" date (these dates are provided in the CMS Plan Communications User Guide). Under this specific condition PDP sponsors may utilize a code 62 enrollment transaction to directly submit the request to CMS as provided in the CMS Plan Communications User Guide.

If additional documentation needed to make the request complete is not received within the timeframe above, the organization must deny the enrollment request using the procedures outlined in §30.2.3.

Requesting Information from the Applicant - To obtain information to complete the enrollment, the PDP sponsor must contact the individual to obtain the information within

10 calendar days of receipt of the enrollment request (see Exhibit 3). If the contact is made orally (by phone), the PDP sponsor must document the contact and retain the documentation in its records. While CMS has provided a model notice, we would encourage plans to obtain information by the most expedient means available. The PDP sponsor must explain to the individual that if the information is not received within the timeframes described above, the enrollment will be denied. If the PDP sponsor denies the enrollment request, the sponsor must provide the individual with a notice of denial of enrollment (see Exhibit 6).

If all documentation is received within allowable time frames and the enrollment request is complete, the PDP sponsor must transmit the enrollment to CMS within the time frames prescribed in §30.3, and must provide the individual with the information described in §30.4

30.2.3 - PDP Sponsor Denial of Enrollment

A PDP sponsor must deny an enrollment within 10 calendar days of receiving an enrollment request based on (1) Its own determination of the ineligibility of the individual to elect the PDP plan (e.g. individual not having a valid enrollment period to elect a plan) and/or, (2) An individual not providing information to complete the enrollment request within the time frames described in §30.2.2.

PDP sponsor denials occur **before** the organization has transmitted the enrollment to CMS. For example, it may be obvious that the individual is not eligible to elect the plan due to place of residence. This “up-front” denial determination must be within 10 calendar days from the date of receipt of an enrollment request.

Notice Requirement - The organization must provide a notice of denial to the individual that includes an explanation of the reason for the denial (see Exhibit 6). This notice must be provided within 10 calendar days of either 1) receipt of the enrollment request or 2) expiration of the time frame for receipt of requested additional information, as described in the following examples:

EXAMPLE

- A PDP sponsor receives an enrollment request from an individual on December 8th and determines on that same day that the individual is ineligible due to place of residence. The organization must provide the notice of denial within 10 calendar days from December 8.
- A PDP sponsor receives an enrollment form on December 8th from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information, on December 10. The beneficiary does not submit the information by December 31 (as required under §30.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within ten calendar days from December 31.

30.3 - Transmission of Enrollments to CMS

For all enrollment requests effective January 1, 2008, and after that the organization is not denying per the requirements in §30.2.3, the PDP sponsor must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the PDP sponsor within 7 calendar days of receipt of the complete enrollment request. All enrollment requests must be processed in chronological order by date of receipt of the enrollment request

PDP sponsors are encouraged to submit transactions on a flow basis and as early as possible to resolve the many data issues that arise from late submissions. However, if the organization misses the cutoff date, it must still submit the transactions within the required 7-day time frame.

NOTE: The 7-day requirement to submit the transaction does not delay the effective date of the individual's enrollment in the PDP, i.e., the effective date must be established according to the procedures outlined in §20.4.

30.4 - Information Provided to Member

Much of the enrollment information that a PDP sponsor must provide to the enrolling individual must be provided prior to the effective date of enrollment. However, some information will be provided after the effective date of coverage. A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.

As discussed previously (section 30), the PDP sponsor must provide required notices in response to information received by CMS on the TRR that provides the earliest notification. In most instances, the weekly TRR will contain the earliest notification

The PDP sponsor may provide the required notices described in §§30.4.1 and 30.4.2 in a single ("combination") notice (see Exhibit 2b). The combination notice takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance. To use the combination notice, the sponsor must be able to provide this notice within 7 calendar days of availability of the TRR. Additionally, when following this option to use the combination notice, if the PDP sponsor is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end of the month), the sponsor still must ensure that the beneficiary has the information required in §30.4.1 within these timeframes described therein.

30.4.1 - Prior to the Effective Date of Enrollment

Prior to the effective date of enrollment, the PDP sponsor must provide the member with all the necessary information about being a Medicare member of the PDP, including the PDP rules, and the member's rights and responsibilities (an exception to this requirement

is described in §30.4.2.). In addition, the PDP sponsor must provide the following to the individual:

- A copy of the completed *paper* enrollment form, if the individual does not already have a copy of the form;
- *For enrollment requests submitted via the internet, evidence that the online enrollment request was received (e.g. a confirmation of receipt number).*
- A notice acknowledging receipt of the enrollment request providing the expected effective date of enrollment (see **Exhibit 2**). This notice must be sent no later than 10 calendar days after receipt of the completed enrollment request; and
- Proof of health insurance coverage so that he/she may begin using the plan services as of the effective date. This proof must include the 4Rx data necessary to access benefits.

NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in–CMS’ marketing guidelines. The proof of coverage provided may be in the form of member ID cards, the enrollment form, and/or a notice to the member (refer to Exhibit 2, which is a model letter with optional language that would allow the member to use the letter as proof of coverage until he/she receives a member card. As of the effective date of enrollment, plan systems should indicate active membership.

Regardless of whether an enrollment request is made in a face-to-face interview, by fax, by mail, or by any other mechanism defined and allowed by CMS, the PDP sponsor must explain:

- The charges for which the prospective member will be liable, e.g., any premiums (*this includes any Part D late enrollment penalty*), coinsurance, fees or other amounts; (including general information about the low income subsidy).
- The prospective member’s consent to the disclosure and exchange of necessary information between the PDP sponsor and CMS.
- The potential for member liability if it is found that the member is not eligible for Part D at the time coverage begins and the member has used PDP services after the effective date.
- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card).

Requirements for providing information to individuals enrolled via the auto-enrollment and facilitated enrollment processes are outlined §30.1.4.

30.4.2 - After the Effective Date of Coverage

CMS recognizes that for some enrollment requests, the PDP sponsor will be unable to provide the materials to the individual, including notification of the effective date, prior to the effective date, as generally required in §30.4.1. These cases will usually occur only when an enrollment request is received by the PDP sponsor in the last few days of a month, and the effective date is the first of the upcoming month. In these cases, the PDP sponsor still must provide the individual all materials described above no later than 10 calendar days after receipt of the enrollment request. In these cases, the PDP sponsor is also strongly encouraged to call these new members as soon as possible (such as within 1 - 3 calendar days) to provide the effective date, information to access benefits and explain the PDP rules. The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

Acceptance/Rejection of Enrollment - Once the PDP sponsor receives a TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the PDP sponsor must notify the individual of CMS' acceptance or rejection of the enrollment within 10 calendar days of the availability of the weekly or monthly TRR, whichever contains the earliest notification of the acceptance/rejection (see **Exhibits 4 and 7**). The enrollment confirmation notice must explain the charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.

There are exceptions to this notice requirement for certain types of transaction rejections. These exceptions exist so as not to penalize the individual for a systems issue or delay, such as a plan transmission or keying error. In addition, this notice requirement does not apply to the scenario in which a transaction rejection due to no Medicare Part A and/or no Medicare Part B is received but the PDP sponsor has evidence to the contrary. In this case, the PDP sponsor must request a retroactive enrollment correction from CMS (or its designee) within *the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor*. If CMS (or its designee) is unable to process the enrollment correction due to its determination that the individual indeed does not have Medicare Part A or Part B, the PDP sponsor must reject the enrollment and must notify the individual of the rejection within 10 calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §50.3.

If a PDP sponsor rejects an enrollment request and later receives additional information from the individual showing entitlement to Medicare Part A and/or enrollment in Part B, the PDP sponsor must obtain a new enrollment request from the individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §50.3 for more information regarding retroactive enrollments.

30.5 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive action may be necessary (refer to §§50.3 and 50.5 for more information). In addition, a reinstatement to the plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his/her original plan of choice.

An enrollment that is not complete is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if a PDP sponsor or CMS determines at a later date that an incorrect permanent address was provided at the time of enrollment and the actual permanent address is outside the PDP's service area.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, CMS does not regard an enrollment as actually complete if the individual, or his/her legal representative, did not intend to enroll in the PDP. If there is evidence that the individual did not intend to enroll in the PDP, the PDP sponsor should submit a retroactive disenrollment request to CMS (or *the CMS Retroactive Processing Contractor*). Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should be signing;
- Request by the individual for cancellation of enrollment before the effective date (refer to §50.1.1 for procedures for processing cancellations);

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the individual may believe that he/she was purchasing a supplemental health insurance policy, as opposed to enrolling in a PDP.

40 - Disenrollment Procedures

42 CFR 423.36 & 423.44

Except as provided for in this section, a PDP sponsor may not, either orally or in writing or by any action or inaction, request or encourage any enrollee to disenroll from a PDP. While a PDP sponsor may contact members to determine the reason for disenrollment, the PDP sponsor must not discourage members from disenrolling after they indicate their desire to do so. The PDP sponsor must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

All notice requirements are summarized in **Appendix 1**. The PDP sponsor must provide disenrollment notices in response to transaction replies received from CMS based upon the TRR.

40.1 - Voluntary Disenrollment by an Individual

A member may request disenrollment from a PDP plan *only* during one of the periods outlined in §§20.2 and 20.3. The member may disenroll by:

1. Enrolling in another plan (during a valid enrollment period);
2. Giving or faxing a signed written notice to the PDP sponsor, or through *the member's* employer/union group, where applicable;
3. Submitting a request via Internet to the PDP sponsor (if the PDP sponsor offers such an option);
4. Calling 1-800-MEDICARE.

If a member verbally requests disenrollment from the PDP, the PDP sponsor must instruct the member to make the request via one of the methods outlined above. The PDP sponsor may send a disenrollment form to the member upon request (see Exhibits 8 and 9).

The disenrollment request must be dated when it is received by the PDP sponsor.

When someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

- 1) Attest that he or she has the authority under State law to make the disenrollment request on behalf of the individual;
- 2) Attest that proof of this authorization (if any), as required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS; and
- 3) Provide contact information.

40.1.1 – Requests Submitted via Internet

The PDP sponsor has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The PDP sponsor must, at a minimum, comply with the CMS security policies - found at <http://www.hhs.gov/informationsecurity/>.

The PDP sponsor may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies also require PDP sponsors to provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the sponsor is complying with the required encryption, authentication, and identification requirements. The effective date of the request is determined by the election period in which the valid request was received by the sponsor. The election period is determined by the date the request is received at the site designated by the sponsor.

The option of online disenrollment is limited to requests submitted via the PDP sponsor's website. Online disenrollment via other means, such as a broker website, as well as disenrollment requests submitted via email, are not permitted.

CMS reserves the right to audit the PDP sponsor to ascertain whether it is in compliance with the security policy.

40.1.2 – Request Signature and Date

When requesting voluntary disenrollment by submitting a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §30.2.1 for more detail on who may complete enrollment and disenrollment requests). If the request is not signed, see section 40.4.2 for information to complete the disenrollment request.

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the PDP sponsor places on the request form will serve as the signature date.

If a written disenrollment request is received and the signature is not included, the sponsor may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

40.1.3 – Effective Date of Disenrollment

The election period during which a valid request to disenroll was received by the PDP organization will determine the effective date of the disenrollment request; refer to §20.5 for information regarding disenrollment effective dates.

With the exception of some SEPs and when periods overlap, individuals may not choose the effective date of disenrollment. Instead, the PDP sponsor is responsible for assigning the appropriate effective date based on the enrollment period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the PDP sponsor staff are responsible for ensuring that a beneficiary does not attempt to choose an effective date that is not allowed under the requirements outlined in §20.5.

If an individual submits a disenrollment request with an unallowable effective date, the PDP sponsor must contact the beneficiary to explain that the disenrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the contact must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary may cancel the disenrollment according to the procedures outlined in §50.2.2 prior to the effective date.

40.1.4 – PDP Sponsor Denial of Voluntary Disenrollment Request

If the PDP sponsor receives a disenrollment request that it must deny, the PDP sponsor must notify the enrollee within 10 calendar days of the receipt of the request, and must include the reason for the denial (see Exhibit 11).

A PDP sponsor may deny a voluntary request for disenrollment only when:

1. The request was made outside of an allowable period as described in §20 of this guidance; or
2. The request was made by someone other than the enrollee and that individual is not the enrollee's legal representative (as described in §30.2.1).
3. *The request was incomplete and the required information) is not provided within the required time frame.*

40.1.5 – Notice Requirements

After the member submits a disenrollment request, the PDP sponsor must provide the individual a disenrollment notice within ten (10) calendar days of the date the request to disenroll was received (see Exhibit 10). The disenrollment notice must include an explanation that the individual remains enrolled in the PDP until the effective date of the disenrollment. For these types of disenrollments (i.e., disenrollments in which the individual has disenrolled directly through the PDP sponsor, PDP sponsors are

encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment *via* the TRR.

Since Medicare beneficiaries have the option of disenrolling through 1-800-MEDICARE, or by enrolling in another Part D plan, the PDP sponsor will not always receive a request for disenrollment directly from the individual but will instead learn of the disenrollment through the TRR. If the PDP sponsor learns of the disenrollment from the TRR (as opposed to through the receipt of a request from the enrollee), the PDP sponsor must send a notice of confirmation of the disenrollment to the individual within 10 calendar days of the availability of the TRR (see Exhibit 10a). *The disenrollment confirmation notice is not required for automatic disenrollments resulting from an individual's enrollment in a PBP within the same Part D contract.*

For denials of voluntary disenrollment requests as described in §40.1.4, the denial notice must be sent within 10 calendar days of the date the disenrollment request was received. It must also include the reason for denial (see **Exhibit 11**).

40.2 - Required Involuntary Disenrollment

A PDP organization must disenroll an individual from a PDP in the following cases.

1. A change in residence (including incarceration) *makes* the individual ineligible to be an enrollee of the PDP (§40.2.1)
2. The individual loses entitlement to Medicare (§40.2.2);
3. The individual dies (§40.2.3); or
4. The PDP contract is terminated, the PDP sponsor discontinues offering a PDP or reduces the plan service area such that the individual no longer resides in the plan service area (§40.2.4); or
5. The individual materially misrepresents information to the PDP sponsor regarding reimbursement for third-party coverage (§40.2.5).
6. *The member receives financial support from a current or former employer/union group (or spouse's current or former employer/union group) for medical or prescription drug coverage and his/her plan will renew as a Part D payment demonstration plan.*

Incarceration – For Part D plans, a member who is incarcerated is considered to be residing outside the plan service area, even if the correctional facility is located within the plan service area. However, *sponsors must disregard* past periods of incarceration that *have been served to completion if those periods* have not already been addressed by a sponsor or by CMS.

Notice Requirements - In situations where the sponsor disenrolls the member involuntarily on any basis except death or loss of entitlement, notices of the upcoming disenrollment meeting the following requirements must be sent. All disenrollment notices must:

1. Advise the member that the sponsor is planning to disenroll the member and why such action is occurring;
2. Be mailed to the member before submission of the disenrollment transaction to CMS; and
3. Include an explanation of the member's right to a hearing under the sponsor's grievance procedures. (This explanation is not required if the disenrollment is a result of plan termination or service area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and area reductions, which are provided in separate instructions to sponsors.)

40.2.1 - Sponsor Receives Notification of Possible Residence Change

The Part D sponsor must disenroll an individual when an individual (or legal representative) notifies the PDP that he or she *has moved and* no longer resides in the service area of a PDP. The sponsor must retain documentation of the permanent change of address and disenroll the individual. If the sponsor offers another PDP in the region *into* which the beneficiary *has moved*, the sponsor may use this opportunity to inform the beneficiary of its other PDP product(s).

If the PDP sponsor learns of a beneficiary address change that is outside the PDP service area from either CMS (i.e. a state and county code change on the TRR) or from the U.S. Postal Service (USPS), it must follow the "Researching and Acting on a Change of Address" procedures outlined below.

An SEP, as defined in §20.3.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another MA or Part D plan (either a PDP or MA-PD) during this SEP.

40.2.1.1 – General Rule

The Part D sponsor must disenroll a member if:

1. He/she permanently moves out of the service area;
2. The member's temporary absence from the service area exceeds 6 consecutive months;
3. The member is incarcerated and, therefore, out of area.

40.2.1.2 – Effective Date

Disenrollment is effective on the first of the month following the month in which the individual (or his or her legal representative) *notifies the PDP sponsor that s/he has moved and no longer resides in the plan service area*. In the case of an individual who provides advance notice of the move, the disenrollment *will* be the first of the month following the month in which the individual indicates he/she will be moving. In the case of incarcerated individuals, sponsors may receive notification of the individual's out-of-area status via a TRR; *disenrollment is effective the first of the month following the sponsor's confirmation of a current incarceration*. If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the sponsor can submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment as a result of receiving information from either CMS or the U.S. Post Office that the individual has not confirmed will be effective the first day of the calendar month after 6 months have passed.

40.2.1.3 - Researching and Acting on a Change of Address

Within ten calendar days of receiving information from either CMS or the USPS that a beneficiary *may* no longer reside in the service area, a PDP sponsor must make an attempt to contact the member to *determine* the *beneficiary's* permanent *residence* and *must* document its efforts in doing so. In the case of incarcerated individuals, the PDP may also confirm the individual's out-of-area (i.e. incarcerated) status with public sources (such as a state/federal government entity or other public records) rather than direct contact with the individual. The PDP sponsor may *accept* either written or verbal *confirmation that an individual has moved out of the service area*, as long as the PDP sponsor applies the policy consistently among all members. PDP sponsors may disregard past periods of incarceration that have been served to completion and have not already been addressed by a plan or CMS.

If the PDP sponsor does not receive confirmation from the member (or his or her legal representative) within a six month period, the PDP sponsor must initiate disenrollment. The six month period will begin on the date the change of address is identified (e.g. through the TRR or forward address notification from the USPS).

When researching changes of address, CMS encourages sponsors to utilize resources available to them, including any CMS systems interfaces, internet search tools, address information from provider claims, etc.

40.2.1.4 – Special Procedures for Auto and Facilitated Enrollees Whose Address Is Outside the PDP Region

CMS assigns most beneficiaries based on the State Medicaid Agency that reports the individual as dual eligible, even if that state is different than that in the address on CMS' systems. In addition, beneficiaries may move after auto/facilitated enrollment occurs. If the PDP sponsor discovers that an individual whom CMS had auto/facilitated enrolled *or reassigned* has an address outside of the PDP sponsors' region (e.g. via a state and county code change on the TRR or the USPS), the PDP sponsor must make an attempt to *determine the beneficiary's* permanent *residence* and *must* document its efforts in doing so. The PDP sponsor may *accept* either written or verbal *confirmation that an individual has moved out of the service area*, as long as the PDP sponsor applies the policy consistently among all members.

If the sponsor confirms **the move is temporary**, the PDP sponsor must retain the individual as a member.

If the sponsor confirms **the move is permanent** and has a PDP in the new region that offers a basic benefit package (i.e. other than enhanced) with a premium at or below the low-income premium subsidy amount for that region, the PDP organization may submit an enrollment transaction to enroll the beneficiary in that PDP prospectively (See Exhibit 27). In this event, no enrollment form or other election is necessary. However, an enrollment form is necessary if the beneficiary chooses to enroll into another type of plan (e.g. enhanced) in the new region.

If the sponsor confirms **the move is permanent** and does not have a PDP in the new region that offers a basic benefit package with a premium at or below the low-income premium subsidy amount for that region, the PDP sponsor must inform the beneficiary that s/he must enroll in a PDP that serves the area where s/he now resides. *The Sponsor must disenroll the beneficiary*, effective the first of following month (see Exhibit 28).

If the sponsor is unable to contact the auto/facilitated enrolled beneficiary, or receives no response, the PDP sponsor should not disenroll the beneficiary. This includes situations in which the beneficiary *'s address is listed as* a P.O. Box.

40.2.1.5 - Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the USPS will return any materials mailed first-class by the sponsor as undeliverable.

Note: For auto and facilitated enrollees, CMS provides PDP sponsors with mailing addresses as maintained in CMS systems. These addresses are not always current, and in cases where the beneficiary has a representative payee, the address of the payee will be the address of record in CMS systems.

In the event that any member materials are returned as undeliverable, the PDP sponsor must take the following steps:

1. If the USPS returns mail with a new forwarding address, forward plan materials *to* the beneficiary and advise the plan member to change his or her address with the Social Security Administration.
2. If the sponsor receives documented proof from the USPS of a beneficiary change that is outside of the PDP region or mail is returned without a forwarding address, follow the procedures outlined above.
3. If the beneficiary uses his or her drug coverage at a pharmacy in the plan's network, the sponsor may choose to follow up with the pharmacy to obtain the member's current address.
4. If the sponsor is successful in locating the beneficiary, advise the beneficiary to update records with the Social Security Administration by:
 - a. Calling their toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 7:00 a.m. to 7:00 p.m. EST;
 - b.* Going to <http://www.ssa.gov/changeaddress.html> on the SSA website; or
 - c.* Notifying the local SSA field office. A beneficiary can get addresses and directions to SSA field offices from the Social Security Office Locator which is available on the Internet at: <http://www.socialsecurity.gov/locator>.

A PDP sponsor is expected to mail beneficiary materials to the undeliverable address, as a forwarding address may become available at a later date, and is encouraged to continue to research addresses as described in the "Researching and acting on change of address" above.

40.2.1.6 – Notice Requirements

1. **Part D sponsor notified of out-of-area permanent move** - When the sponsor receives notice of a permanent change in address from the individual, it must provide notification of disenrollment to the member. This notice must be provided within 10 calendar days of the PDP sponsor's learning of the permanent move.
2. **Out of area for 6 months** - When the individual has been out of the service area for 6 months after the date the sponsor learned of the change in address from either CMS or the USPS and the sponsor has not been able to obtain confirmation, the sponsor must provide notification of the upcoming disenrollment to the individual.

The notice of disenrollment must be provided within the first ten calendar days of the 6th month. The notice should advise the member to notify the PDP sponsor as soon as possible if the information is incorrect.

CMS strongly encourages that sponsors send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use plan services.

40.2.2 - Loss of Eligibility for Part D

An individual who is no longer entitled to either Medicare Part A and/or Part B benefits may not remain enrolled in a PDP. The sponsor will be notified by CMS that part D eligibility has ended. CMS will make the disenrollment effective the first day of the month following the last month of Part D eligibility.

Notice Requirements – Notice must be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 14) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §50.2.1.

40.2.3 - Death

CMS will disenroll an individual from a PDP sponsor upon his/her death and CMS will notify the Part D sponsor that the individual has died. This disenrollment is effective the first day of the calendar month following the month of death. Sponsors may not submit disenrollment transactions to CMS in response to the apparent death of a member. In the anticipation of official notification from CMS via the TRR, the sponsor may, at its discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices.

Notice Requirements - Following the receipt of a CMS notification (via TRR) of disenrollment due to death, a notice must be sent to the member or the estate of the member (see Exhibit 13) so that any erroneous disenrollments can be corrected as soon as possible. The sponsor must send this notice within 10 days of the notification via the TRR. In cases of erroneous disenrollment and notification, refer to §50.2.1.

40.2.4 - Terminations/Nonrenewals

The PDP sponsor must disenroll an individual from a PDP if the PDP contract is terminated, the PDP sponsor discontinues offering the PDP or the PDP sponsor reduces the plan service area such that the individual no longer resides in the plan service area.

An individual who is disenrolled under these provisions has an SEP, as described in §20.4.3, to enroll in a different Part D plan.

Notice Requirements - The PDP sponsor must give each affected individual a written notice of the effective date of the termination, and include a description of alternatives for obtaining benefits under the Medicare program. CMS will provide further guidance to affected sponsors, as required by 42 CFR 423.507 - 423.509.

40.2.5 - Material Misrepresentation Regarding Third-Party Reimbursement

If a PDP enrollee intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires that the individual be disenrolled from the PDP. Involuntary disenrollment for this reason requires CMS approval. The PDP sponsor must submit any information it has regarding the claim of material misrepresentation to its CMS account manager for review. Disenrollment for material misrepresentation of this information is effective the first of the month following the month in which the enrollee is notified of the disenrollment, or as CMS specifies.

40.3 - Optional Involuntary Disenrollments

A PDP sponsor may disenroll a member from a PDP it offers if:

- Premiums are not paid on a timely basis (§40.3.1);
- The member engages in disruptive behavior (§40.3.2); or
- The member provides fraudulent information on an enrollment request, or if the member permits abuse of an enrollment card in the PDP (§40.3.3).

Notice Requirements - In situations where the PDP sponsor disenrolls the member involuntarily for any of the reasons addressed above, the PDP sponsor must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the PDP sponsor is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and
- Includes an explanation of the member's right to a hearing under the PDP sponsor's grievance procedures.

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

40.3.1 - Failure to Pay Premiums

Part D sponsors may not disenroll a member who fails to pay plan cost sharing under this provision. However, a sponsor has two options when a member fails to pay plan

premiums *(this includes any Part D late enrollment penalty per Chapter 4 of the Prescription Drug Benefit Manual)*.

For each of its Part D plans (i.e. each PBP), the Part D sponsor must take action consistently among all members, i.e., a sponsor may have different policies among its different Part D plans, but it may not have different policies within a plan.

The Part D sponsor may:

1. Do nothing, i.e., allow the member to remain enrolled in the same PDP;
2. Disenroll the member after a grace period and proper notice.

If the sponsor chooses to disenroll the member, this action may only be accomplished by the sponsor after the sponsor makes a reasonable effort to collect the payment and notice has been provided to the member (as described below). If payment has not been received within a grace period, the individual will be disenrolled.

Sponsors **may not** disenroll members for failure to pay premiums (or notify them of impending disenrollment) in cases where the member has requested that premiums be withheld from his/her Social Security benefit check until the sponsor receives a TRR indicating that the member's request has been rejected. The sponsor must then notify the member of the premium owed, provide the appropriate grace period, and comply with other applicable requirements prior to disenrolling the member.

Sponsors may not involuntarily disenroll any individuals who are considered to be in premium withhold status by CMS. Individuals who have requested premium withhold are considered to remain in premium withhold status until either (1) CMS notifies the sponsor that the premium-withhold request has rejected, failed, or been unsuccessful; or (2) the member requests that he/she be billed directly. Only after one of these actions occurs may a member's status be changed to "direct bill." Once the member is considered to be in "direct bill" status, the sponsor must notify the member of the premium owed and provide the appropriate grace period, as described below. Sponsors must always provide members the opportunity to pay premiums owed before initiating any disenrollment action.

However, even if a member's premium payment status has been changed to "direct bill" and the member can demonstrate that SSA has withheld Part C and/or Part D premiums during the coverage month(s) in question, the member will be considered to remain in premium withhold status.

Example 1 – Incorrect Continuation of Premium Withhold: Individual was enrolled in Plan A and selected premium withhold. Individual subsequently enrolls in Plan B and does not select premium withhold. Upon receiving a direct bill from Plan B, the individual provides Plan B with proof that a premium deduction continues from his SSA benefit check. Since the member provided Plan B with

evidence that a premium amount is currently being deducted from his check, Plan B cannot initiate the process to disenroll the individual for failure to pay premiums. Plan B must work with CMS to obtain appropriate premium reimbursement.

Further, an individual will continue to be considered in premium withhold status if a plan is notified by CMS that the member's request for premium withholding is not successful as a result of systems/fund transfer issues between CMS and the Social Security Administration (SSA), or between CMS and the sponsor. CMS recognizes that in some instances sponsors have not received premium amounts in their monthly CMS plan payment for members who have elected Social Security withholding; however, sponsors cannot hold their members responsible for such issues, nor penalize them by attempting to disenroll them from their plan. Therefore, the sponsor **may not** initiate the billing (and subsequent disenrollment process, if necessary) until a member is in "direct bill" status.

Example 2 – Incorrect Data Due to Systems Miscommunication: An individual requests premium withhold and Plan A correctly submits the request to CMS. The transaction request is submitted successfully by CMS to SSA and the appropriate premium amount is deducted from the individual's SSA benefit check. However, due to a systems issue between CMS and SSA, the premium withhold data is not correctly reflected in CMS systems. Thus, CMS does not pay the correct premium amount to Plan A. Plan A must work with CMS to obtain appropriate premium reimbursement and may **not** initiate the disenrollment process for the individual for failure to pay premiums while the premium continues to be withheld.

CMS reminds sponsors that they **may not** disenroll a member or initiate the disenrollment process if the sponsor has been notified that a State Pharmaceutical Assistance Program (SPAP) or other payer intends to pay the entire Part D premium on behalf of an individual. (Section 50.6 of Chapter 14 of the PDP Manual.)

While the sponsor may accept partial payments, it has the right to ask for full payment within the grace period. If the member does not pay the required amount within the grace period, the effective date of disenrollment is the first day of the month after the grace period ends. **The PDP sponsor has the right to take action to collect the unpaid premiums from the beneficiary at any point during or after this process.**

If a member is disenrolled for failure to pay premiums and attempts to re-enroll in the organization, the PDP sponsor may require the individual to pay any outstanding premiums owed to the PDP sponsor before accepting the enrollment.

If the individual is involuntarily disenrolled for failure to pay premiums, in order to re-enroll in that plan, or to enroll in another, the individual must request enrollment during a valid period. *Payment of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums.*

Calculating the Grace Period

A PDP sponsor must provide plan enrollees with a grace period of not less than 1 calendar month; however, it may provide a grace period that is longer than 1 *calendar* month, at its discretion. The grace period must be a whole number of *calendar* months and cannot include fractions of months.

The **grace period** must be a minimum of 1 calendar month that begins on the 1st day of the month for which the premium is unpaid. The sponsor is required to have billed the member prior to the start of the grace period for the actual premium amount due, with such notice/bill specifying the due date for that amount. The sponsor must also provide the member with an opportunity to pay. For new enrollees, a PDP sponsor must wait until notified by CMS of the actual premium which the beneficiary is responsible for paying directly before the individual can be notified of/billed for the amount due; for these individuals, the due date cannot be until after the sponsor receives notification from CMS as to the beneficiary's premium and notifies the individual of the amount due. The grace period can then begin no earlier than the first day of the month on or after the due date.

PDP sponsors have the following options in calculating and applying the grace period. The organization must apply the same option for all members of a plan.

Option 1 - PDP sponsors may consider the grace period to end not less than 1 calendar month after the first day of the month for which premium is unpaid.

If the overdue premium and all other premiums that become due during the grace period (in accordance with the terms of the member's agreement with the PDP sponsor) are not paid in full by the end of the grace period, the PDP sponsor may terminate the member's coverage.

As mentioned previously, the individual must be notified/billed of the actual premium amount due before the premium can be considered "unpaid." For new enrollees, at a minimum, this cannot occur until CMS notifies the PDP sponsor of the total premium due from the individual. Upon CMS notification, the PDP sponsor would bill the individual of the amount due, with a prospective due date.

Under this scenario, PDP sponsors are encouraged to send subsequent notices as reminders or to show that additional premiums are due. Subsequent notices, therefore, should determine the expiration date of the grace period by reference to this date. Notice requirements are summarized in this section under the heading "notice requirements."

Example A: Plan XYZ has a 1-month grace period for premium payment. Plan member Mr. Stone's premium was due on February 1, 2010. He did not pay this premium and on February 7th, the PDP sponsor sent an appropriate notice. Mr. Stone ignores this notice and any subsequent premium bills. The grace period is the month of February. If Mr.

Stone does not pay his plan premium before the end of February, he will be disenrolled as of March 1, 2010.

Example B: Plan QRS has a 2-month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2010. She did not pay this premium and on July 6th, the PDP sponsor sent an appropriate notice. Mrs. Monsoon ignores this notice and subsequent premium bills. The grace period is the months of July and August. If Mrs. Monsoon does not pay her premiums in full by the end of this period (August 31st), she will be disenrolled effective September 1, 2010.

The PDP sponsor must state that it requires the member to make full payment within the grace period, and pay all premiums falling due within that period, in its initial delinquency notice to the member if it chooses this policy.

Option 2 - PDP sponsors may use a “rollover” approach in applying the grace period.

Under this scenario, the grace period would begin on the first of the month for which the premium is unpaid, but if the member makes a premium payment within the grace period, the grace period stops *and is revised to reflect the new disenrollment date, depending on the number of months for which premiums are received*. The member would then have a new grace period beginning on the 1st day of the next month for which the premium is due. *The subsequent notice also would have to be sent within 10 calendar days (or 15 calendar days, as described below) of the next premium due date*. This process continues until the member's balance for delinquent premiums *is* paid in full or until the grace period expires with no premium payments being made, at which time the sponsor *may disenroll* the member.

Sponsors are not required to issue new notices each time the member submits a partial premium payment (i.e. less than one month's premium), since this would not result in a change in the proposed disenrollment date. However, since payment of at least one month's past-due premium causes the disenrollment date to “roll over” (i.e. move forward) commensurate with the number of month's premium received, sponsors must issue a notice warning of the potential for involuntary disenrollment (see Exhibit 19) which includes the new disenrollment date whenever payment of at least one month's premium is received during the grace period. These subsequent notices are required to be sent within 10 (or 15) calendar days of the premium due date that follows receipt of the premium payment.

EXAMPLE

Plan WXY has decided to offer a 2 –month grace period for non-payment of plan premiums and has chosen the “rollover” approach to calculating the grace period. A member fails to pay his January premium due January 1. The sponsor sends a notice to the member on January 7th stating that his coverage will be terminated if the outstanding premium is not paid within the grace period. The notice advises him that his termination date would be March 1. The member then pays the January premium, but does not pay

the February premium. The grace period is recalculated to begin on the 1st of the next month for which the premium is unpaid (February 1). *On February 9th* the sponsor sends a notice to the member reflecting the new grace period and the new anticipated termination date of April 1st. The member pays off his balance in full before the grace period expires, therefore the member's coverage in the PDP remains intact.

Notice Requirements - If it is the sponsor's policy to disenroll the member when a member has not paid plan premiums, the sponsor must send an appropriate written notice (see Exhibit 19) to the member as follows:

- If the sponsor has a grace period of 1 calendar month, the PDP sponsor must send a notice of non-payment of premiums **within** 10 calendar days after the premium due date.
- If the sponsor has a grace period of 2 or more months, the PDP sponsor must send this notice of non-payment of premiums **within** 15 calendar days after the premium due date.

The sponsor may send interim notices after the initial notice. In addition to the notice requirements outlined in §50.3, this notice must:

- Alert the member that the premiums are delinquent;
- Provide the member with an explanation of disenrollment procedures advising the member that failure to pay the premiums within the grace period that began on the 1st of the month for which premium was unpaid will result in termination, and the proposed effective date of this action; and
- Explain whether the sponsor requires full payment within the grace period (including the payment of all premiums falling due during the intervening days, when and as they become due, according to the terms of the membership agreement) in order to avoid termination.

If a member does not pay within the grace period, and the sponsor's policy is to disenroll the member, the sponsor must notify the member in writing providing the effective date of the member's disenrollment (see Exhibit 20) and submit a disenrollment transaction to CMS. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the grace period; however, in no case may the disenrollment notice to the individual be sent after the transaction is submitted to CMS. In the event the sponsor submits a disenrollment request to CMS and later learns that payment was received timely, a reinstatement request must be submitted to CMS (or its designee). In addition, the sponsor must send final confirmation of disenrollment to the member within 10 calendar days of receiving the TRR (see Exhibit 21).

Optional Exception for Individuals who Qualify for Low Income Subsidy (LIS)

Sponsors have the **option** to retain individuals who qualify for the low income subsidy who fail to pay premiums even if the PDP sponsor has a policy to disenroll members for non-payment of premiums.

The PDP sponsor has the discretion to offer this option to individuals who qualify for the low income subsidy within each of its PDPs. If the PDP sponsor offers this option in one of its PDPs, it must apply the policy to all such individuals in that PDP.

Example: “If you have Medicaid or extra help in paying for your Medicare prescription drugs and are having difficulty paying your plan premiums or cost sharing, please contact us.”

The sponsor must document this policy internally and have it available for CMS review.

40.3.2 - Disruptive Behavior

The PDP sponsor **may** request to disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the PDP substantially impairs the PDP sponsor’s ability to arrange for or provide services to either that particular member or other members of the PDP. However, the PDP sponsor may only disenroll a member for disruptive behavior after it has met the requirements of this section and with CMS’ approval. The PDP sponsor may not disenroll a member because he/she exercises the option to make treatment decisions with which the PDP sponsor disagrees. The PDP sponsor may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the PDP sponsor or any health care professionals associated with the PDP sponsor.

Before requesting CMS’ approval of disenrollment for disruptive behavior, the PDP sponsor must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The PDP sponsor must also inform the individual of his or her right to use the organization’s grievance procedures.

The PDP sponsor must submit documentation of the specific case to CMS for review. This includes documentation:

- Of the disruptive behavior;
- Of the PDP sponsor’s serious efforts to resolve the problem with the individual;
- Of the PDP sponsor’s effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;

- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances cited under 42 CFR §423.44(d)(2)(iii) and (iv);
- That the PDP sponsor provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the PDP sponsor then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The PDP sponsor must submit to the CMS Regional Office:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the PDP sponsor's ability to arrange for or provide services to the individual or other members of the PDP;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.
- The PDP sponsor may request that CMS consider prohibiting re-enrollment in the PDP (or PDPs) offered by the PDP sponsor in the service area.

The PDP sponsor's request for involuntary disenrollment for disruptive behavior must be complete, as described above. The CMS Regional Office will review this documentation and consult with CMS Central Office (CO), including staff with appropriate clinical or medical expertise, and decide whether the organization may involuntarily disenroll the member. Such review will include any documentation or information provided either by the organization and the member (information provided by the member must be forwarded by the organization to the CMS RO). CMS will make the decision within 20 business days after receipt of all the information required to complete its review. CMS will notify the PDP sponsor within 5 (five) business days after making its decision.

The Regional Office will obtain Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment, or as provided by CMS.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the PDP sponsor to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable

accommodation in this context is that CMS could require the PDP sponsor to delay the effective date of involuntary disenrollment to coordinate with an enrollment period that would permit the individual an opportunity to obtain other coverage. If necessary, CMS will establish an SEP on a case-by-case basis.

Notice Requirements

The disenrollment for disruptive behavior process requires 3 (three) written notices:

- Advance notice to inform the member that the consequences of continued disruptive behavior will be disenrollment;
- Notice of intent to request CMS' permission to disenroll the member; and
- A planned action notice advising that CMS has approved the PDP sponsor's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the PDP sponsor must provide the member with written notice explaining that his/her continued behavior may result in involuntary disenrollment, and that cessation of the undesirable behavior may prevent this action. The notice must also inform the individual of his or her right to use the organization's grievance procedures. The PDP sponsor must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the PDP sponsor must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the PDP sponsor's efforts, then the PDP sponsor must notify him/her of its intent to request CMS' permission to disenroll him/her for disruptive behavior. This notice must also advise the member of his/her right to use the organization's grievance procedures and to submit any information or explanation. The PDP sponsor must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS.

Planned Action Notice

If CMS permits a PDP sponsor to disenroll a member for disruptive behavior, the PDP sponsor must provide the member with a written notice that contains, in addition to the notice requirements outlined in §40.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. The PDP sponsor may only provide the member with this required notice after CMS notifies the PDP sponsor of its approval of the request.

The PDP sponsor can only submit the disenrollment transaction to CMS after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the PDP sponsor gives the member a written notice of the disenrollment, or as provided by CMS.

40.3.3 - Fraud and Abuse

A PDP sponsor may request to *cancel the enrollment of* a member who knowingly provides fraudulent information on the enrollment request that materially affects the member's eligibility to enroll in the plan. The sponsor may also request to disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider. Such a disenrollment is effective the first day of the calendar month after the month in which the sponsor gives the member the written notice.

With such a disenrollment request, the sponsor must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

Notice Requirements - The PDP sponsor must give the member a written notice of the disenrollment that contains the information required at §40.3.

40.4 - Processing Disenrollments

Procedures for processing voluntary and involuntary disenrollments are described below.

40.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from an enrollee, the PDP sponsor is responsible for submitting disenrollment transactions to CMS in a timely, accurate fashion. Such transmissions for disenrollment requests effective January 1, 2008, and after must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The PDP sponsor must maintain a system for receiving, controlling, and processing voluntary disenrollments from the PDP sponsor. This system should include:

- Dating each disenrollment request as of the date it is received (regardless of whether the request is complete at the time it is received by the PDP sponsor) to establish the date of receipt;
- Dating supporting documents for disenrollment requests as of the date they are received;

- Determining if the voluntary request is valid according to the requirements in §40.1 of this guidance;
- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;
- Transmitting disenrollment information to CMS within 7 calendar days of the receipt of the completed disenrollment request from the individual or the employer/union group (whichever applies);
- For disenrollment requests received by the PDP sponsor, to notify the member in writing within 10 calendar days after receiving the member's written request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see Exhibit 10). PDP sponsors are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the TRR.

When the voluntary disenrollment request is denied, the PDP sponsor must send written notice within 10 calendar days of the receipt of the request and include the reason for denial (see Exhibit 11).

- For all other voluntary disenrollments (i.e. voluntary disenrollments made by the beneficiary through 1-800-MEDICARE, or by enrolling in another Medicare health plan or PDP, which the PDP sponsor would not learn of until receiving the TRR), the PDP sponsor must notify the member in writing to confirm the effective date of disenrollment within 10 calendar days of the availability of the TRR (see Exhibit 11).

40.4.2 - When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the PDP sponsor must document all efforts to obtain additional documentation to complete the disenrollment request and have an audit trail to document why additional documentation was needed before the request could be considered complete. *The organization must make this determination, and, within 10 calendar days of receipt of the disenrollment request, must notify the individual that additional information is needed.*

If a written disenrollment request is submitted and the signature is not included, the PDP sponsor may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

For AEP elections, additional documentation to make the request complete must be received by December 31, or within 21 calendar days (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the disenrollment request was initially received, or within 21 calendar days (whichever is later).

40.4.3 - Involuntary Disenrollments

The PDP sponsor is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The PDP sponsor must maintain a system for controlling and processing involuntary disenrollments from the PDP sponsor. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and
- For all involuntary disenrollments except disenrollments due to death and loss of entitlement to Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights, as provided in the applicable section of this guidance.

In addition, PDP sponsors must send confirmation of involuntary disenrollment to ensure the member discontinues use of PDP sponsor services after the disenrollment date.

40.5 - Disenrollments Not Legally Valid

When a disenrollment request that is not legally valid has been processed, a reinstatement action may be necessary (refer to §50.2 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §40.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her legal representative did not intend to disenroll from the PDP. If there is evidence that the member did not intend to disenroll from the PDP, the PDP sponsor should submit a reinstatement request to CMS (or its designee). Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or
- Request by the member for cancellation of disenrollment before the effective date (refer to §50.1 for procedures for processing cancellations).

Discontinuation of payment of premiums does not necessarily indicate that the member has made an informed decision to disenroll.

In contrast, CMS believes that a member's deliberate attempt to disenroll from a plan (e.g., sending a written request for disenrollment to the PDP sponsor, or calling 1-800-MEDICARE) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

40.6 - Disenrollment Procedures for Employer /Union Sponsored Coverage Terminations

The employer/union establishes criteria for its retirees to participate in the employer/union sponsored PDP plan. These criteria are exclusive of the eligibility criteria for PDP enrollment. Eligibility criteria to participate and receive employer/union sponsored benefits may include spouse/family status, payment to the employer/union of the individual's part of the premium, or other criteria determined by the employer/union. For this reason, when *the contract between* an employer or union group *and* a PDP sponsor *is terminated*, or *the employer/union* determines that a beneficiary is no longer eligible to participate in the employer/ union sponsored plan, the PDP sponsor has the option to follow one of two procedures to disenroll beneficiaries from the current employer/union sponsored PDP plan in which the individual is enrolled:

For both of these options, the PDP sponsor must ensure that the employer/union agrees to the following:

- The employer/union will provide the PDP sponsor with timely notice of contract termination or the ineligibility of the individual to participate in the employer/union group. Such notice must be prospective, not retroactive.
- The employer/union must provide a prospective notice to its members alerting them of the termination event and of other insurance options that may be available to them through their employer/union.

Option 1: Enroll the individual(s) in another PDP (i.e. individual plan) offered by the same PDP sponsor, unless the individual(s) make other choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area.

- Beneficiaries may elect another PDP or MA-PD offered by the employer or union, disenroll from the PDP, or join another PDP or MA-PD plan as an individual member, if he/she chooses, instead of electing the new PDP offered by the employer/union.

- If the beneficiary prefers not to be enrolled in the individual plan, he/she may contact the sponsor.
- If the beneficiary would prefer enrolling in a different PDP or MA-PD plan as an individual member, he/she would submit an enrollment request to his/her newly chosen PDP or MA organization.
- If the individual takes no other action, he/she will become a member of the individual plan offered by the same PDP sponsor that offered the employer/union sponsored plan.
- **PDP Notice requirements** -- The PDP sponsor (or the employer or union acting on its behalf) must provide prospective notice to the beneficiary that his/her plan is changing, including information about benefits, premiums, and/or copayments, at least 21 calendar days prior to the effective date of enrollment in the individual plan.

Option 2: Disenroll individual(s) from the PDP sponsor following prospective notice.

- **PDP Notice requirements** - The PDP sponsor (or the employer or union, acting on its behalf) must provide prospective notice to the beneficiary that his/her plan enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the beneficiary may choose and how to request enrollment.
- If the employer/union group sponsored plan was a PDP, the individual must be advised that the disenrollment action means that the individual will not have Medicare drug coverage. Notice must include information about the potential for late-enrollment penalties that may apply in the future.

The PDP sponsor must outline in its written policies and procedures the option(s) it follows *and must apply the same option for all members of a particular employer/union sponsored plan*. It is the PDP sponsor's responsibility to ensure that the *required elements of the disenrollment procedures described above are* understood by the employer/union and *are* part of the agreement with each employer/union, including contract termination notification requirements.

40.6.1 – Group Disenrollment for Employer/Union Sponsored PDPs

CMS has provided, under our authority to waive or modify Part D requirements that hinder the design of, the offering of, or the enrollment in an employer or union sponsored

Part D retiree plans, a process for group disenrollment from employer or union sponsored PDPs.

CMS will allow an employer or union group to disenroll its retirees from a PDP using a group disenrollment process.

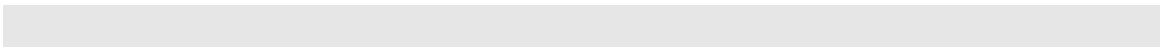
The group disenrollment process must include notification to each beneficiary as follows:

- All beneficiaries must be notified that the group intends to disenroll them from the PDP that the group is offering; and
- This notice must be provided not less than 21 calendar days prior to the effective date of the beneficiary's disenrollment from the group sponsored PDP.

Additionally, the information provided must include an explanation on how to contact Medicare for information on other Part D options that might be available to the beneficiaries.

The employer or union group must have and provide all the information required for the PDP sponsor to submit a complete disenrollment request transaction to CMS as described in this and other CMS Part D systems guidance.

NOTE: This process applies to employer/union group direct contract PDP sponsors and MA Organizations and PDP sponsors that offer employer/union group-only plans.



50 - Post-Enrollment Activities

42 CFR 423.32 & 423.36

Post-enrollment activities occur after the PDP sponsor receives the enrollment request from the individual.

50.1 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment or disenrollment made by an individual. Unless otherwise directed by CMS, requests for cancellations can only be accepted prior to the effective date of the enrollment or disenrollment request. For employer or union groups, cancellations properly made to the employer or union prior to the effective date of the election being canceled are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary.

If a beneficiary verbally requests a cancellation of an enrollment or disenrollment request, the PDP sponsor must document the request and process the cancellation. PDP sponsors may request that the cancellation be made in writing to the PDP sponsor, however, they may not delay processing of a cancellation until the request is made in writing if they have already received a verbal request from the individual of the desire to cancel the enrollment or disenrollment.

50.1.1 - Cancellation of Enrollment

An individual's enrollment can be cancelled only if the request is received prior to the effective date of the enrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the PDP sponsor should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment by the time it receives the request for cancellation, it may attempt to submit a corresponding disenrollment transaction to CMS to "cancel out" the now void enrollment transaction from the CMS enrollment system. In the event the PDP sponsor has submitted the enrollment and is unable to submit a corresponding disenrollment transaction, or has other difficulty, the PDP sponsor should contact the CMS RO in order to cancel the enrollment.

When canceling an enrollment the PDP sponsor must provide a notice to the individual that states that the cancellation is being processed. This notice should be sent within 10 calendar days of the receipt of the cancellation request (see Exhibit 22).

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation generally cannot be processed. The PDP sponsor must inform the member that he/she is a member of its plan. If he/she wants to get back into the other

PDP he/she will have to fill out an enrollment form to enroll in that plan during an enrollment period, and with a current effective date.

50.1.2 - Cancellation of Disenrollment

A voluntary disenrollment request can only be cancelled by the individual if the request for cancellation is made prior to the effective date of the disenrollment unless otherwise directed by CMS.

To ensure the cancellation is honored, the PDP sponsor should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it may attempt to submit a corresponding enrollment transaction to CMS to “cancel out” the now void disenrollment transaction. In the event the PDP sponsor has submitted the disenrollment and is unable to submit the “canceling” enrollment transaction, or has other difficulty, the PDP sponsor then the organization should contact CMS (or *the CMS Retroactive Processing Contractor*) in order to cancel the disenrollment.

The PDP sponsor must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using PDP services (see Exhibit 23). This notice should be sent within 10 calendar days of the request.

If the member’s request for cancellation occurs after the effective date of the disenrollment, then the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §50.2.2. If a reinstatement will not be allowed, the PDP sponsor should instruct the member to fill out and sign a new enrollment form to re-enroll with the PDP sponsor during an enrollment period (described in §20), and with a current effective date, using the appropriate effective date as prescribed in §20.5.

50.2 - Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §40.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are:

1. Disenrollment due to erroneous death indicator,
2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator, and
3. Mistaken disenrollment. In unique circumstances, a sponsor may consult with CMS (or its designee) to reinstate members.

When a disenrolled member contacts the PDP sponsor to state that he/she was disenrolled due to any of the reasons listed above, and states that he/she wants to remain a member of the PDP, then the PDP sponsor must instruct the member in writing to continue to use

PDP services (refer to Exhibit 15, Exhibit 16, Exhibit 17 and Exhibit 18 for model letters). *The notice must be sent within ten calendar days of the individual's contact with the sponsor to report the erroneous disenrollment. Accordingly, plan systems should indicate active membership as of the date the organization instructs the individual to continue to use plan services.*

A reinstatement is viewed as a correction necessary to “erase” an invalid disenrollment action and to ensure no gaps in coverage occur. Therefore, reinstatements may be made retroactively. *Payment of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums.*

CMS (or its designee), will *review requests for* reinstatement on a case-by-case basis.

50.2.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Part D Eligibility Indicator

A member can be reinstated if he/she was disenrolled due to an erroneous death or loss of Part D eligibility indicator since he/she was always entitled to remain enrolled. *Although sponsors may request that individuals provide evidence of Medicare entitlement by a particular date, erroneous disenrollments must be corrected and the corresponding reinstatements processed, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of Medicare entitlement.*

To request *consideration for* reinstatement *following* disenrollment due to erroneous death indicator or erroneous loss of Part D eligibility, the PDP sponsor *must* submit to CMS (or its designee) *a* copy of the letter to the member informing him/her to continue to use PDP coverage until the issue is resolved. *The reinstatement request must indicate the date on which this letter was sent to the member.* Refer to model letters in Exhibits 15 and 16.

50.2.2 - Reinstatements Due to Mistaken Disenrollment Made By Member

As stated in §40.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who are able to cancel the disenrollment before the effective date of the disenrollment (as outlined in §40.2.2), given that this type of cancellation generally results in no changes to CMS records.

Requests Made Prior to the Effective Date of the Erroneous Disenrollment

Reinstatements will be allowed at the request of a member who enrolled in another PDP, which resulted in an erroneous disenrollment from the original PDP in which he/she was enrolled, and who was able to cancel the enrollment in the another PDP (as outlined in §40.2.1). When a cancellation of enrollment in another PDP is properly made, the

associated automatic disenrollment from the first PDP becomes invalid. Generally, these reinstatements will be granted only when the member submits the request for reinstatement in writing in the time frames described in the next paragraph, and has used pharmacy services only from providers in the original (first) PDP since the original effective date of the disenrollment.

Verbal Requests for Reinstatement Due to Erroneous Disenrollment

For reinstatement requests due to mistaken disenrollment by the member, when the disenrolled member verbally contacts the original PDP sponsor to state that he/she mistakenly disenrolled, and states that he/she wants to remain a member of the plan, the PDP sponsor must instruct the member to notify the PDP sponsor in writing of *his/her* desire to remain enrolled in the plan *and that in order to consider the reinstatement request, this written statement must be received by the sponsor no later than 30 calendar days from the date* the PDP sponsor sent the notice of disenrollment to the individual (see Exhibit 10a). Regardless of whether the request for reinstatement is verbal or in writing, the PDP sponsor must also instruct the member to continue to use PDP plan services (see Exhibit 17). *Accordingly, plan systems should indicate active membership (with no break) as of the date the organization instructs the individual to continue to use plan services.*

If the PDP sponsor does not receive the written statement from the member within the required time frame, it must close out the reinstatement request by notifying the individual of the denial of reinstatement (see Exhibit 18), and should do so within 10 calendar days after the date the member's written request was due at the PDP sponsor.

To request reinstatement in response to a mistaken disenrollment by the member, the PDP sponsor must submit the following information to CMS (or its designee) *within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor*:

- A copy of the letter to the member informing him/her to continue to use PDP plan services until the issue is resolved and instructing him/her to *provide a written statement of his/her* intent to continue enrollment. Refer to model letter in Exhibit 17; and
- A copy of the written statement from the member indicating he/she wants to remain enrolled in the PDP.

50.3 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the PDP sponsor or CMS is unable to process the enrollment for the required effective date (as outlined in §20.4), CMS (or its designee) will process a retroactive enrollment.

In addition, auto-enrollment for full-benefit dual eligible as described in §30.1.4 may be retroactive to ensure no coverage gap between the end of Medicaid coverage for Part D drugs and the beginning of Medicare drug coverage.

In other limited cases, CMS may determine that an individual is eligible for an SEP due to an extraordinary circumstance beyond his/her control (e.g. a fraudulent enrollment request or misleading marketing practices) and may also permit a retroactive enrollment in a PDP as necessary to prevent a gap in coverage or liability for the late enrollment penalty.

Unlike a reinstatement, which is a correction of records to “erase” an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period.

Occasionally, obtaining the information necessary to complete an enrollment request within the allowable timeframes will extend beyond the CMS systems cut-off date for transaction submission, thus making the effective date of enrollment “retroactive” to the current payment month. In these cases sponsors may utilize the Code 62 enrollment transaction to submit the enrollment transaction directly to CMS.

The *request for a* retroactive enrollment should be made within *the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. When an individual has fulfilled all enrollment requirements, but the sponsor or CMS has been unable to process the enrollment in a timely manner, the following documentation must be submitted to CMS (or its designee):*

- A copy of signed completed enrollment form (the form must have been signed by the *beneficiary (or authorized representative) and received by the sponsor* prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage);

Or

- A copy of the enrollment request record (the record must show that the election was made *and received by the sponsor* prior to the requested effective date of coverage).

In the event that CMS determines that the sponsor did not notify the member that he/she must use plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request *may* be denied.

Special note regarding Regional Office Casework actions

When a sponsor is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the sponsor must provide the following 2 (two) items as documentation to CMS (or its designee):

- A screen print from the Complaint Tracking Module (CTM) or other documentation showing the CMS RO decision *and direction to submit the request to the CMS Retroactive Processing Contractor*

- A copy of the enrollment or disenrollment request, if one is available. Occasionally, due to the nature of casework, this item may not be available. When that occurs, the organization should submit a brief statement of explanation for the missing documentation.

50.4 - Retroactive Disenrollments

If an enrollment was never legally valid (§30.5) or if a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph), which includes not only system error, but plan error), CMS (or its designee) may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §40.2.1), a contract violation, or other limited exceptional conditions established by CMS (e.g. fraudulent enrollment or misleading marketing practices).

Retroactive disenrollments can be submitted to CMS (or its designee) by the beneficiary or a PDP sponsor. Requests from a PDP sponsor must include supporting evidence (e.g. a copy of the disenrollment request) and an explanation as to why the disenrollment was not processed correctly. PDP sponsors must submit retroactive disenrollment requests to CMS (or its designee) as soon as possible. If CMS (or its designee) approves a request for retroactive disenrollment, the PDP sponsor must return any premium paid by the member for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the PDP sponsor (or by the member) in cases where the PDP sponsor has not properly processed or acted upon the member's request for disenrollment as required in §40.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §20.5.

50.5 - Retroactive Transactions for Employer/Union Group Health Plan (EGHP) Members

In some cases a Part D sponsor that has both a Medicare contract and a contract with an EGHP arranges for the employer or union to process elections for Medicare-entitled group members who wish to make elections under the Medicare contract. However, there can be a delay between the time the member completes the election through the EGHP and when the election is received by the PDP sponsor. Therefore, retroactive transactions for these routine delays may be necessary and are provided for under this section. Errors made by an EGHP, such as failing to forward a valid enrollment or disenrollment election within the timeframes described below, must be submitted to CMS (or *the CMS Retroactive Processing Contractor*) for review *within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor*.

Repeated errors may indicate an ongoing problem and therefore will be forwarded to the PDP sponsor's CMS Account Manager for compliance monitoring purposes. The PDP sponsor's agreement with the EGHP must include the need to meet the requirements

provided in this chapter that ensure the timely submission of enrollment and disenrollment requests to reduce the need for retroactivity and to help avoid errors.

50.5.1 - EGHP Retroactive Enrollments

The effective date of EGHP enrollments cannot be *earlier than* the date the enrollment request was completed by the individual. The effective date may be retroactive up to, but not exceeding, 90 days from the date the PDP received the request (which was completed prior to the effective date) from the employer or union group.

EXAMPLE

In March 2007, the CMS system processing date was March 13, 2007. Enrollments processed by CMS for the March 13, 2007 due date were for the prospective April 1, 2007, payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30, 60, and 90 days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP enrollment were to be received on March 5, 2007, the retroactive effective date could be January 1, February 1, or March 1, as long as the enrollment request was completed prior to the effective date.

No retroactive enrollments may be made unless there has been a valid enrollment request and the PDP sponsor (or EGHP) provided him/her with the explanation of enrollee rights at the time of enrollment. The PDP sponsor should submit such enrollments using Transaction Code 60. Please refer to Chapter 19, “Managed Care and MA Systems Requirements” and the Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) for more information. Transaction Code 60 is to be used only for the purpose of submitting a retroactive enrollment into an EGHP made necessary due to the employer’s delay in forwarding the completed enrollment request to the Part D organization.

50.5.2 - EGHP Retroactive Disenrollments

The PDP sponsor must submit a retroactive disenrollment request to CMS (or its designee) if an EGHP does not provide the PDP sponsor with timely notification of a member’s requested disenrollment. Up to a 90-day retroactive payment adjustment is possible in such a case to conform to the adjustments in payment described under 42 CFR 422.250(b). The EGHP notification is considered untimely if it does not result in a disenrollment effective date as outlined in §20.5.

The PDP sponsor must submit a disenrollment notice (i.e., documentation) to CMS (or its designee) demonstrating that the disenrollment request was made in a timely fashion (i.e., prospectively), but that the EGHP was late in providing the information to the PDP sponsor. Such documentation may include an enrollment request made by the member for a different plan and given to the EGHP during the EGHP’s open enrollment season. Such documentation should be sent to CMS (or its designee) as soon as possible.

50.6 – Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment (or disenrollment) request for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than PDP at any given time (however, an individual may be simultaneously enrolled in a cost plan and a separate PDP plan or in certain MA plan types and a separate PDP plan).

Generally, the last enrollment request the beneficiary makes during an enrollment period will be accepted as the PDP into which the individual intends to enroll. If an individual requests enrollment in more than one PDP for the same effective date and with the same application date, the first transaction successfully processed by CMS will take effect. Because simultaneous enrollment in a PDP and certain MA plan types is permitted, CMS systems will accept such enrollments.

Generally, given the use of the application date to determine the intended enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because enrollment requests have the same application date.

EXAMPLES

- Two PDP sponsors receive enrollment requests from one individual. PDP #1 receives a form on December 4th and PDP #2 receives a form on December 10. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in PDP #2 will be the transaction that is accepted and will be effective on January 1 because the application date on the enrollment transaction is the later of the two transactions submitted. Both plans receive the appropriate reply on the TRR.
- Two PDP sponsors receive enrollment requests from one individual for a January 1 effective date. PDP #1 receives a paper enrollment form with all required information on December 5th. The beneficiary completed an enrollment request for PDP #2 by telephone on the same day, December 5th. Both enrollment requests have the same application date, since they were received by the PDP sponsors on the same date. Both enrollments were submitted to CMS prior to the December cut-off date. PDP #1 transmitted the enrollment to CMS on December 5th, the day it received the enrollment request; however, PDP #2 waited December 8th to transmit the enrollment to CMS. The enrollment for PDP #1 will be the transaction that is effective on January 1, as it was the first transaction successfully processed by CMS.

In the event a rejection for a multiple transaction is reported to the PDP sponsor, the sponsor may contact the individual. If the individual wishes to enroll in a PDP offered by the sponsor that received the multiple transactions reject, s/he must submit a new enrollment request during a valid enrollment period.

50.7 - User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

Upon receipt of a TRR, PDP sponsors must update their records to accurately reflect each individual's enrollment status. Sponsors are also required to provide certain notices and information to beneficiaries when enrollment status is confirmed or changes. In the case of UI-TRC replies, the standard operating procedures for providing these notices and/or information may not fit some of the unique situations many UI enrollment changes address.

The table below provides guidelines for communicating with beneficiaries when enrollment changes are reported to PDP sponsors using the "700 series" TRCs that result from UI enrollment changes. In all cases, PDP sponsors will need to review the situations carefully to determine the necessity and appropriateness of sending notices. Some UI enrollment change processes will result in multiple 700-series TRCs being reported. PDP sponsors must determine the final disposition of the beneficiary to ensure the correct message is provided in any notice sent. CMS encourages plans to communicate directly (such as by telephone) with the beneficiary, in addition to any required notice or materials. When it is necessary to send a notice, organizations must issue the notice within ten calendar days of receipt of the TRR.

TRC	Beneficiary Communication Action
701 – New UI Enrollment	Plans may use existing confirmation notices as provided in CMS enrollment guidance. If such notice has already been provided with the same information, it is not necessary to provide it a second time.
702 – New UI Fill-in Enrollment	Plans must use Exhibit 31, "Enrollment Status Update". Include the date range covered by the new fill-in period.
703 – UI Enrollment Cancel	If a cancellation notice applicable to this time period has already been provided, it is not necessary to provide it a second time. If notice has not been provided, plans may use the existing cancellation of enrollment notice as provided in CMS enrollment guidance. If the specific situation warrants, plans may use Exhibit 31 instead, providing information that clearly indicates that the enrollment period in question has been cancelled. Include information about the refunding of plan premiums, if applicable.
704 – <i>UI Enrollment Cancel - PBP Change</i>	If the UI action is a correction to a plan submission error, you may have already provided the correct plan (PBP) information; if that's the case, it is not necessary to send it a second time. If the beneficiary has not received information about the specific plan (PBP), you must send the materials required in CMS enrollment guidance that you would provide for any new enrollment. You must also send Exhibit 31

	describing the plan change including the effective date. Ensure that you communicate clearly the impact of the change on plan premiums, cost sharing, and provider networks. It is not necessary to confirm with a notice the associated “enrollment canceled” TRC that will accompany the enrollment into the new plan (PBP).
705 – <i>New UI Enrollment - PBP Change</i>	Follow the guidance provided above for TRC 704.
706 – <i>UI Enrollment Cancel - Segment change</i>	Plan (PBP) segment changes only apply to MA plans. Provide updated materials reflecting the new elements of the changed segment, such as premium and cost sharing increases or decreases.
707- <i>UI New enrollment - Segment Change</i>	Follow the guidance above for TRC 706.
708 – UI End Date Assigned	This UI action has the same effect as a plan submitted disenrollment (code 51) transaction. Generally, plans should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated changes are retroactive, plans may have already provided notice (with correct effective dates) and if so, need not provide it a second time. Additional clarification may be appropriate depending on the specifics of the case.
709 – UI Earlier Start Date	An existing enrollment period in the plan has changed to start earlier than previously recorded. If the plan has already provided notice reflecting this effective date of enrollment, it is not necessary to provide it a second time. When the individual has not already received notice reflecting this effective date, plans may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, plans may use Exhibit 31, including in it the new effective date and information about additional premium liability (ensure flexibility in allowing payment arrangements where necessary). Plans must also ensure individuals are fully aware of how to access coverage of services for the new time period, including their right to appeal.
710 – UI Later Start Date	An existing enrollment period start date has been changed to start on a later date. Plans must use Exhibit 31. Plans must explain the change in the effective date of coverage, and provide information on the refunding of any premiums paid. Plans must also explain the impact on any paid claims from the time period affected.
711 – UI Earlier End Date	An enrollment period end date has been changed to occur earlier. Plans must use Exhibit 31. Plans must explain the change in the effective date of the end coverage, and provide

	information on the refunding of any premiums paid. Plans must also explain the impact on any paid claims from the time period affected
712 – UI Later End Date	An enrollment period end date has been changed to occur later. Plans must use Exhibit 31. Plans must explain the change in the effective date of the end of coverage, and provide information on any premiums the individual may owe for the extended period. Plans must also ensure beneficiaries are fully aware of how to access coverage of services for the new time period.
713 – UI Removed End Date	An enrollment period that previously had an end date is now open (and ongoing). Plans must use Exhibit 31 to explain the change and that enrollment in the plan is now continuous. Plans must provide information on any plan premiums and ensure beneficiaries are fully aware of how to access coverage of services for the new time period and going forward.

50.8 - Storage of Enrollment and Disenrollment Request Records

PDP sponsors are required to retain records of enrollment and disenrollment requests (i.e. copies of enrollment forms, etc.) for the current contract period and 10 (ten) prior periods, as stated at 42 CFR §423.505(e)(1)(iii).

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment elections may also be allowed, such as optically scanned forms stored on disk.

Records of PDP enrollment and disenrollment elections made by any other election mechanism (as described in §30.1) must also be retained as above.

APPENDICES

Summary of PDP Notice and Data Element Requirements

Appendix 1: Summary of Notice Requirements

This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within this Guidance.

Notice	Section	Required ?	Timeframe
Medicare Prescription Drug Plan Individual Enrollment Form (Exh. 1)	30.1.1	Yes ¹	NA
Optional information to include on or with Enrollment Form -- Information to Determine Enrollment Periods (Exh. 1a)	20	No	NA
Short Enrollment Form (Exh 1b)	10.2 30.1.1	No	NA
Acknowledge Receipt of Enrollment Request (Exh. 2)	30.4.1	Yes ²	10 calendar days of receipt of completed enrollment request
Acknowledge Receipt of Enrollment Request – Enrollment in another Plan Within the Same PDP Organization (Exh. 2a)	30.4.1	Yes	10 calendar days of receipt of completed enrollment request
Acknowledge Receipt of Enrollment and Confirmation of Enrollment (Exh. 2b)	30 and 30.4	Yes ³	7 calendar days of availability of TRR
Request for Information (Exh. 3)	30.2.2	No	NA
Confirmation of Enrollment (Exh. 4)	30.4.2	Yes ⁴	10 calendar days of availability of TRR
Individuals Identified on CMS Records As Members of Employer/Union Receiving Employer Subsidy (Exh. 5)	10.4	Yes	10 calendar days of availability of TRR
PDP Organization Denial of Enrollment (Exh. 6)	30.2.3	Yes	10 calendar days of receipt of enrollment request OR expiration of time frame for

¹ Other CMS approved enrollment election mechanisms may take the place of an enrollment form

² Unless combine acknowledgment & confirmation notice, per section 30.4

³ Required if the PDP sponsor has chosen to provide a single notice in response to the weekly TRR, as described in section 30 and 30.4

⁴ Required unless combined acknowledgment/confirmation notice is issued

Notice	Section	Required ?	Timeframe
			requested additional information
CMS Rejection of Enrollment (Exh. 7)	30.4.3	Yes	10 calendar days of availability of TRR
Send Out Disenrollment Form/ Disenrollment Form (Exh. 8 – 9)	40.1	No	NA
Acknowledgement of Receipt of Voluntary Disenrollment Request from Member (Exh. 10)	40.1.5	Yes	10 calendar days of receipt of request to disenroll
<i>Final Confirmation of Voluntary Disenrollment Identified Through TRR (Exh. 10a)</i>	<i>40.1.5</i>	<i>Yes</i>	<i>10 calendar days of availability of TRR</i>
Confirm Disenrollment Identified Through TRR – Reassigned LIS (Exh. 10b)	<i>30.1.5</i>	Yes	<i>10 calendar days of availability of TRR</i>
PDP Denial of Disenrollment (Exh. 11)	40.1.5	Yes	10 calendar days of receipt of disenrollment request
CMS Rejection of Disenrollment (Exh. 12)	40.1.5	Yes	10 calendar of availability of TRR
Disenrollment Due to Death (Exh. 13)	40.2.3	Yes	10 calendar days of availability of TRR
PDP Model Notice for auto-enrollments provided by CMS with recent deceased code (Exh. 13a)	30.1.4.D	Yes	10 calendar days of availability of TRR
Disenrollment Due to Loss of Medicare Part A and/or Part B (Exh. 14)	40.2.2	Yes	10 calendar days of availability of TRR
Notices on Terminations/Nonrenewals	note ⁵	Yes	Follow requirements in 42 CFR 423.506 - 423.512
Advanced Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	40.3.2	Yes	
Intent to request CMS' permission to disenroll the member	40.3.2	Yes	
Confirmation of Disenrollment for Disruptive Behavior (no exhibit)	40.3.2	Yes	Before disenrollment transaction submitted to CMS
Disenrollment for Fraud &	40.3.3	Yes	Before disenrollment transaction

⁵ Provided under separate CMS guidance

Notice	Section	Required ?	Timeframe
Abuse (no exhibit)			submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	50.2.1	Yes	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination (Exh. 16)	50.2.1	Yes	10 calendar days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another PDP Organization (Exh. 17)	50.2.2	Yes	10 calendar days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	50.2	Yes	10 calendar days after information was due to organization
Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage (Exh. 19)	40.3.1	Yes	Within 10 calendar days after the 1 st of the month for which delinquent premiums due
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	40.3.1	Yes	3 business days following the last day of the grace period
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	40.3.1	Yes	10 calendar days of availability of TRR
Acknowledgement of Request to Cancel Enrollment (Exh. 22)	40.3.1	Yes	10 calendar days of request
Acknowledgement of Request to Cancel Disenrollment (Exh. 23)	50.1.1	Yes	10 calendar days of request
Inform member of Auto-enrollment (Exh. 24)	30.1.4.D	Yes	10 calendar days of availability of TRR or address report, whichever is later
Inform member of Facilitated Enrollment (Exh. 25)	30.1.4.D	Yes	10 calendar days of availability of TRR or address report, whichever is later
Request to Decline Part D (Exh. 26)	30.1.4.E & 30.1.4.E	Yes	10 calendar days of request
Auto and Facilitated Enrollees Who Permanently Reside in	40.2.1	No	10 calendar days of availability of TRR

Notice	Section	Required ?	Timeframe
another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 27)			
Auto and Facilitated Enrollees Who Permanently Reside in another Region Where PDP Sponsor Does Not offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 28)	40.2.1	Yes	10 calendar days of <i>confirmation that individual does not reside in region</i>
Reassignment Confirmation (Exh. 29)	30.1.5E	Yes	
Optional Notice for “Losing Plan” to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC) (Exh. 30)	30.1.5E	No	
Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes (Exh. 31)	50.7	As necessary	10 calendar days of availability of TRR
Model Employer/Union Group Enrollment Mechanism Notice	30.1.6	Yes	Minimum 21 calendar days prior to effective date of enrollment
<i>Research Potential Out of Area Status (Exh. 33)</i>	<i>40.2.1.3</i>	<i>Yes</i>	<i>10 calendar days of receipt of information indicating potential out-of-area status</i>
<i>PDP Model Notice for Disenrollment Due Out of Area Status (Exh. 34)</i>	<i>40.2.1.3</i>	<i>Yes</i>	<i>Within the first ten calendar days of the 6th month</i>
<i>PDP Notice of Disenrollment Due to Out of Area Status (Exh 35)</i>	<i>40.2.1.3</i>	<i>Yes</i>	<i>Within 10 calendar days of confirmation that out-of-area move was permanent</i>

Appendix 2: Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests

All data elements with a “Yes” in the “Required before enrollment complete” column are necessary in order for the enrollment *request* to be considered complete.

Data Element		Required on enrollment mechanism?	Beneficiary response required on enrollment request?
1	PDP Plan name	Yes	Yes
2	PDP plan/product	Yes	Yes
3	Beneficiary name	Yes	Yes
4	Beneficiary Birth Date	Yes	Yes
5	Beneficiary Sex	Yes	Yes
6	Beneficiary Telephone Number	Yes	No
7	Permanent Residence Address	Yes	Yes
8	Mailing Address	Yes	No
9	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	No
10	E-mail address	No	No
11	Beneficiary Medicare number	Yes	Yes
12	Additional Medicare information contained on sample Medicare card, or copy of card	Yes	No ⁶
13	Plan Premium Payment Option	No	No ⁷
14	Other insurance COB information	No	No ⁸
15	Long term care question	No	No
16	Beneficiary signature and/or Beneficiary Representative Signature	Yes	Yes ⁹
17	Date of signature	Yes	No ¹⁰

⁶ We recognize that the PDP needs, at a minimum, the Medicare number in order to verify entitlement to Part A and/or enrollment in Part B; we have accounted for the need for this data element under data element number 4.

⁷ Response defaults to direct bill if applicant fails to provide information

⁸ Refer to CMS COB guidance for additional information

⁹ Applicable only to requests made using a paper enrollment form. If signature is missing, plan may follow up and document, as described in Section 30.2. F

¹⁰ As explained in §30.2, the beneficiary and/or legal representative should provide the date s/he completed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment request, then the date of receipt that the PDP assigns to the enrollment request may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

Data Element		Required on enrollment mechanism?	Beneficiary response required on enrollment request?
18	Authorized Representative contact information (if not signed by beneficiary)	Yes	Yes
19	Information provided under “please read and sign below” All elements provided in model language must be included on enrollment request mechanisms. Option -- can be provided as narrative or listed as statements of understanding	Yes	Yes
20	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes	Yes
21	For enrollments into a Part D Payment Demonstration plan, attestation regarding financial support for purchase of prescription drugs	Yes	Yes
22	<i>Option to request materials in language other than English or in other formats</i>	<i>Yes</i>	<i>No</i>

Appendix 3: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the beneficiary's choice of plan is honored. The application date is always a date prior to the effective date of enrollment.

Election Mechanism	Application Date	Special Notes
Paper Enrollment Forms §40.1.1	The date the paper request is initially received	Paper requests submitted to or collected by sales agents or brokers are received by the PDP sponsor on the date the agent or broker receives the form
Enrollment forms received by Fax §40.1.1	The date the fax is received on the PDP sponsor's Fax machine	
Medicare.gov Online Enrollment Center (OEC) §40.1.3	The date "stamped" by CMS on the request	
PDP Web site online enrollment page §40.1.3	The date the request is completed via the sponsor's website process	
Approved Telephonic Enrollment §40.1.4	The date of the call	
Other Special Processes for Application Dates		
All enrollment requests into employer or union sponsored plans, regardless of mechanism used	1 st day of the month prior to the effective date of enrollment	This applies to all mechanisms including §§40.1.3 and 40.1.7
Auto and Facilitated Enrollment §40.1.6	For Part D plans, the application date is set by CMS.	For Cost plans conducting auto- & facilitated enrollment per section 40.1.1 of Chapter 17-D, set the application date to the 1 st of the month prior to the effective date of the auto/facilitated enrollment.
SPAP enrollment requests as permitted in §40.1.8 made during the AEP	November 15 th of the current year	The effective date of enrollment is the following January 1 st
CMS required plan-submitted "rollover" transactions	November 14 th of the current year	The effective date of enrollment is the following January 1 st . CMS approval is required as described in §30 of this guidance.

EXHIBITS

PDP Model Enrollment Forms & Notices

Exhibit 1 - PDP Model Enrollment Form

[Logo/Name of the Medicare Drug Plan]




<PDP Name> Medicare Prescription Drug Plan Individual Enrollment Form

Please contact <plan name> if you need information in another language or format (Braille).

To *Enroll* in <PDP name>, Please Provide *the F*ollowing Information:

[Optional Field] Please check which plan you want to enroll in: ____ Product ABC \$XX per month ____ Product XYZ \$XX per month				
LAST name:		FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (__ __/__ __/__ __ __ __) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F			Home Phone Number: ()
Permanent Residence Street Address (<i>P.O. Box is not allowed</i>):				
City:		State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):				
Street Address:		City:	State:	ZIP Code:
Emergency contact: [Optional field] _____				
Phone Number: [Optional field] _____ Relationship to You [Optional field] _____				
[optional field] E-mail Address: _____				

Please Provide Your Medicare Insurance Information

<p>Please take out your Medicare <i>card</i> to complete this section.</p> <ul style="list-style-type: none">• Please fill in these blanks so they match your red, white and blue Medicare card- OR -• Attach a copy of your Medicare card or your letter from Social Security or <i>the</i> Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<table border="1"><tr><td colspan="2"></td></tr><tr><td colspan="2">SAMPLE ONLY</td></tr><tr><td colspan="2">Name: _____</td></tr><tr><td>Medicare Claim Number ____ - ____ - ____ - ____</td><td>Sex ____</td></tr><tr><td>Is Entitled To HOSPITAL (Part A) _____ MEDICAL (Part B) _____</td><td>Effective Date _____</td></tr></table>			SAMPLE ONLY		Name: _____		Medicare Claim Number ____ - ____ - ____ - ____	Sex ____	Is Entitled To HOSPITAL (Part A) _____ MEDICAL (Part B) _____	Effective Date _____
											
SAMPLE ONLY											
Name: _____											
Medicare Claim Number ____ - ____ - ____ - ____	Sex ____										
Is Entitled To HOSPITAL (Part A) _____ MEDICAL (Part B) _____	Effective Date _____										

Paying Your Plan Premium

You can pay your monthly plan premium by mail *<insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”> each month* *<insert optional intervals, if applicable, for example “or quarterly”>.* **You can also choose to pay your premium by automatic deduction from your Social Security *benefit check* each month.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you *don't* select a payment option, you will receive a bill each month *<optional language in place of “bill each month”: “coupon book” or “payment book”>.*

Please select a premium payment option:

- ☐ Receive a bill *<option: “coupon”, “payment” book, etc>*
<option to include other billing intervals e.g. bi-monthly, quarterly>

<Include other optional methods, such as EFT & credit card as follows:

- ☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ Checking ☐ Saving

- ☐ Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: _____

Expiration Date: __/__/____ (MM/YYYY)>

- ☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please Answer the Following Questions:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <PDP name>? ☐ Yes ☐ No

If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If “yes” please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

Please check one of the boxes below if you would prefer *that we* send you information in a language other than English or in another format:

____ <include list of available languages>

____ <include list of other formats (e.g. Braille, audio tape, or large print)>

Please contact <*PDP* name> at <phone number> if you need information in another format or language than what is listed above. *TTY users should call <TTY number>*. Our office hours are <insert days and hours of operation>.



Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug *coverage* from your Medicare Advantage *Plan* that will meet your needs. By joining <PDP name>, your membership in your Medicare Advantage *Plan* may end. This will affect both your doctor and hospital coverage as well as your prescription drug *coverage*. Read the information that your Medicare Advantage *Plan* sends you and if you have questions, contact your Medicare Advantage *Plan*.

If you currently have health coverage from an employer or union, joining <PDP Name> could affect your employer or union health benefits. *You could lose your employer or union health coverage if you join <PDP name>*. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there *isn't* information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

<PDP Name> is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare *Part A or Part B* coverage. It is my responsibility to inform <PDP name> of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare *Prescription Drug Plan*, my enrollment in <PDP name> will end that enrollment.

<Contract#, Material ID#, CMS approval date (if applicable)>

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15 – December 31), unless I qualify for certain special circumstances.

<PDP Name> serves a specific service area. If I move out of the area that <PDP Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except *in an emergency* when I cannot reasonably use <PDP name> network pharmacies. Once I am a member of <PDP Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from <PDP name> when I *get* it to know which rules I must follow to *get* coverage.

I understand that if I leave this plan and *don't* have or *get* other Medicare prescription drug coverage or creditable *prescription drug* coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

[Insert the following for Part D payment demonstration plan: By joining this plan, I *confirm* that I am not *getting* any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) *to buy* medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage *Plan* or Medicare *Prescription Drug Plan*.]

I understand that if I am *getting* assistance from a sales agent, broker, or other individual employed by or contracted with <PDP name>, he/she may be *paid* based on my enrollment in <PDP name>. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug *Plan* options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that <PDP Name> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <PDP Name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on *my* behalf under State *law* where *I live*) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <PDP Name> or by Medicare.

Signature:	Today's Date:
-------------------	----------------------

If you are the authorized representative, you must sign above and provide the following information:

Name : _____

Address: _____

Phone Number: (____) ____- ____

Relationship to Enrollee _____

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative/agent/broker Signature: _____

[optional space for other administrative information needed by plan]

Exhibit 1a – Information to Include on or with Enrollment Mechanism - Attestation of Eligibility for an Enrollment Period

Referenced in section: 20

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between November 15 and December 31 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan *or I recently moved and this plan is a new option for me. I moved on (insert date) _____.*
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I *get* extra help paying for Medicare prescription drug coverage.
- ☐ I no longer *qualify* for extra help paying for my Medicare prescription drug *coverage. I stopped receiving extra help on (insert date) _____.*
- ☐ I live in or recently moved out of a *Long-Term* Care Facility (for example, a nursing home or long term care facility). *I moved/will move into/out of the facility on (insert date) _____.*
- ☐ I recently left a PACE program *on (insert date) _____.*
- ☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). *I lost my drug coverage on (insert date) _____.*
- ☐ I am leaving employer or union coverage *on (insert date) _____.*
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently returned to the United States after living permanently outside of the U.S. *I returned to the U.S. on (insert date) _____.*
- ☐ None of these statements applies to me.*

*Please contact <plan name> at <phone number> to see if you are eligible to enroll. We are open <insert days and hours of operation>. *TTY users should call <TTY number>.*

Exhibit 1b – Model Short Enrollment Form (“Election” may also be used)

This form may be used in place of the model individual enrollment form when a member of a PDP sponsor is enrolling into another plan benefit package with the same PDP sponsor.

Referenced in section(s): 10.3, 30.1.2, Appendix 1

Name of Plan You are Enrolling In: _____		
Name:	Medicare Number: _____ <i>/Note: may use “member number” instead of “Medicare number”/</i>	
Home Phone Number: _____		
Permanent Street Address: _____		
City: _____	State: _____	ZIP Code: _____
Mailing Address (only if different from your Permanent Street Address):		
Street Address: _____	City: _____	State: _____ ZIP Code: _____
Please fill out the following:		
I am currently a member of the _____ plan in <PDP name> with a monthly premium of \$ _____ .		
I would like to change to the _____ plan in <PDP name>. I understand that this plan has different prescription benefits and a monthly premium of \$ _____.		
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:		
<input type="checkbox"/> <include list of available languages>		
<input type="checkbox"/> <include list of other formats (e.g. Braille, audio tape, or large print)>		
Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.		

Your Plan Premium
You can pay your monthly plan premium by mail <i><insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”></i> each month <i><insert optional intervals, if applicable, for example “or quarterly”>.</i> You can also choose to pay your premium by automatic deduction from your Social Security <i>benefits check</i> each month.
<i>People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won’t have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don’t even know it. For more information about this extra help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.</i>
If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover.

If you don't select a payment option, you will **get** a bill each month <optional language in place of "bill each month": "coupon book" or "payment book">.

Please select a premium payment option:

- ☐ **Get** a bill <option: Include other optional methods, such as EFT & credit card>
- ☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please Read and Sign Below:

<PDP name> is a Medicare prescription drug plan and has a contract with the Federal government.

I understand that if I am **getting** assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be compensated based on my enrollment in <plan name>.

Release of Information: By joining this Prescription Drug Plan, I acknowledge that the Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date [name of plan] coverage begins, I must get all of my prescription drug services from <plan name>. Prescription drugs authorized by <plan name> and contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**

[Insert the following for Part D payment demonstration plan: By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.]

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Plan Name> or by Medicare.

Signature:

Today's Date:

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____ - ____

Relationship to Enrollee _____

<Contract#, Material ID#, CMS approval date (if applicable)>

Medicare Prescription Drug Plan Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Plan Representative/agent/broker Signature: _____

[optional space for other administrative information needed by plan]

Exhibit 2 - PDP Model Notice to Acknowledge Receipt of Completed Enrollment

Referenced in section: 30.4.1

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>

Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Your enrollment will be effective on <effective date>.

How will this coverage work?

As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions. [***Optional language:*** This letter is proof of your <PDP name> coverage. You should show this letter at the pharmacy until you get your Member ID card from us.]

How much is my premium?

Medicare must approve all enrollments and calculate your premium amount. When Medicare approves your enrollment into <PDP name>, we will send you a letter to confirm your enrollment in <PDP name>. You will get a separate letter from <PDP name> once Medicare calculates your premium. You should not wait to get these confirmation letters before you begin using <PDP name> network pharmacies on <effective date>. If Medicare rejects your enrollment, <PDP name> will bill you for any prescriptions you received through us.

[PDP plans without a premium – do not use the following Q&A:

Will <PDP name> bill me directly for my premiums or will my premiums be deducted from my Social Security check?

If you chose to have your <PDP name> premium withheld from your Social Security benefit check, remember that your check will reflect this deduction. If you didn't choose this option, we will bill you for your monthly premiums. Generally you must stay with the premium payment option you choose for the rest of the year. [PDPs that disenroll for nonpayment of premium include the following sentence: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who

qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

What if I have other health coverage?

If you have *other* health coverage, *such as* from an employer or union, joining <PDP Name> may change how your current coverage works. Read the communications your *other health* coverage sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. If you have other prescription drug coverage, such as through an employer plan, you shouldn't cancel your other coverage yet. Keep your other coverage until you receive the confirmation letter from us.

What if I have Medigap (Medicare Supplemental Insurance) coverage?

If you have a Medigap (Medicare Supplement Insurance) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

When can I make changes to my Medicare prescription drug coverage?

Medicare limits when you can make changes to your coverage. From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, or you qualify for extra help with your prescription drug costs. From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you have questions about how or when to disenroll from <PDP name>, please call our customer service department.

Where can I fill my prescriptions?

Please remember that you should use <PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below.

What if I have more questions?

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 2a - Model Notice to Acknowledge Receipt of Completed Enrollment in another Plan in the Same Part D Organization

Referenced in section: 30.4.1

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>

Dear < Member>:

Thank you for the request to change your enrollment from <former PDP name> to <new PDP name>. <New PDP name> is a Prescription Drug Plan that is approved by Medicare. Your enrollment will be effective on <effective date>.

How will this coverage work?

As of <effective date>, you should begin using <new PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <new PDP name> may not pay for your prescriptions. [*Optional language:* This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us.]

How much is my premium?

Medicare must approve all enrollments and calculate your premium amount. When Medicare approves your enrollment, we will send you a letter to confirm your enrollment with <new PDP name>. You will get a separate letter from <PDP name> once Medicare calculates your premium. But, you should not wait to get these confirmation letters before you begin using <new PDP name> network pharmacies on <effective date>.

When can I make changes to my prescription drug coverage?

Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area *or you qualify for extra help in paying for your prescription drug costs (see below)*. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. *If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.*

If you have questions about how or when to disenroll from <new PDP name>, please call our customer service department at the phone number at the end of this letter.

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

[PDP plans without a premium – do not use the following Q&A:

Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security check?

If you chose to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. If you did not choose this option, we will bill you for your monthly premium. Generally you must stay with the premium payment option you choose for the rest of the year. *[PDPs that disenroll for nonpayment of premium include the following sentence: “Members who fail to pay the monthly premium may be disenrolled from <PDP name>”.]*

Where can I fill my prescriptions?

Please remember that you should use <new PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <new PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below.

What if I have more questions?

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 2b - PDP Model Notice to Acknowledge Receipt of Completed Enrollment and to Confirm Enrollment

Referenced in section: 30.4.1

<Member #>

<RxID>

<RxGroup>

<RxBin]>

<RxPCN>

<Date>

Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Medicare has approved your enrollment in <PDP name> beginning <effective date>.

How will my coverage work?

As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy *except in* an emergency, <PDP name> may not pay for your prescriptions. *You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service department. [Optional language: This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us.]*

How much is my premium?

[Insert the following if no low-income subsidy: The premium for your plan is: [insert premium]. If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please call <PDP name> at the number provided at the end of this letter.

[Insert if low-income subsidy applicable:

What are my costs since I qualify for extra help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert appropriate LIS deductible amount > for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> when you fill a prescription.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please call <PDP name> at the number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?

[Insert the following for new members with an existing LEP: Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the number provided at the end of this letter. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.] If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.

[If previous paragraph not applicable, insert the following for all other new members: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR*
- You had a break in coverage of at least 63 days.*

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[Part D plans without a premium – do not use the following paragraph:

Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security check?

If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. If you did not choose this option, we will bill you for your monthly premium. Generally you must stay with the premium payment option you choose for the rest of the year. *[PDPs that disenroll for nonpayment of premium include the following sentence: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]*

[Insert if low-income subsidy NOT applicable:

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

What if I have Medigap (Medicare Supplemental Insurance) coverage?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

What if I have more questions?

If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 3 - Model Notice to Request Information

Referenced in section: 30.2.2

<Date>

Dear <Name of Member>:

Thank you for applying with <PDP name>. We cannot process your enrollment until we get the following information from you:

_____ Proof that you have Medicare Part A and/or Part B. Please send us a copy of your Medicare card as proof of your Medicare coverage.

_____ Other: _____

You will need to provide this information to <*PDP* name> by <date>. You can contact us by phone with this information by calling <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. Or, you may also fax it to us at <fax number> or send it to us at <address>. If you cannot send this information by <date>, we will have to deny your request to enroll in our Plan.

Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area *or if you qualify for extra help with your prescription coverage (see below)*. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 4 - PDP Model Notice to Confirm Enrollment

Referenced in section: 30.4.2

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>

Dear <Name of Member>:

Medicare has approved your enrollment in <PDP name> beginning <effective date>.

How will my coverage work?

As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, *except in* an emergency, <PDP name> may not pay for your prescriptions. *You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service department at the number at the end of this letter.*

[Optional language: This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us.]

[Insert the following if no low-income subsidy:

How much is my premium?

The monthly premium for your plan is <premium amount>.

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office. or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <PDP name> at the number provided at the end of this letter.]

[Insert if low-income subsidy applicable:

What are my costs since I qualify for extra help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert appropriate LIS deductible amount > for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount > when you fill a prescription *covered by <PDP name>*.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <PDP name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?

[Insert the following for new members with an existing LEP: Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan.

Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter.

You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.] If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.

[MA-PD plans: If previous paragraph not applicable, insert the following for all other new members:]

The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- *You didn't have other prescription drug coverage that met Medicare's minimum standards; OR*
- *You had a break in coverage of at least 63 days.*

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.

[Part D plans without a premium – do not use the following paragraph:

Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security check?

If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. If you did not choose this option, we will bill you for your monthly premium. Generally you must stay with the premium payment option you choose for the rest of the year. *[PDPs that disenroll for nonpayment of premium include the following sentence: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]*

What if I have a Medigap policy?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

What if I have more questions?

If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 5 - PDP Model Notice to Individuals Identified on CMS Records As Members of Employer/Union Group Receiving Employer Subsidy

Referenced in section: 10.4

<Date>

Dear < Member>:

Thank you for applying with <PDP name>. To finalize your enrollment, we would like you to confirm that you want to be enrolled in <PDP name>.

Medicare has informed us that you belong to an employer or union group health plan that includes prescription drug coverage *that is as good as Medicare prescription drug coverage*.

It is important that you consider your decision to enroll in our Plan carefully. If you have health coverage from an employer or union, joining <PDP Name> may change how your current coverage works. *You could lose your employer or union health coverage, and if you have a spouse or dependents, their coverage also could be lost.* Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help

If you have already discussed this decision with your employer or union contact and have decided that you would like to be a member of <PDP name>, **please *call* <PDP name> at the phone number provided below.** Your enrollment *won't* be complete until you call and confirm this information.

We must hear from you to enroll you in our plan. If we *don't* hear from you within 30 days from the date of this notice, we *won't* process your enrollment.

To confirm your enrollment *and your effective date of <effective date>*, or if you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 6 - PDP Model Notice for Denial of Enrollment

Referenced in section: 30.2.3

<Date>

Dear <Name of Beneficiary>:

Thank you for applying with <PDP name>. We cannot accept your request for enrollment in <PDP name> because of the reason(s) checked below.

1. _____ You have neither Medicare Part A nor Part B.
2. _____ Your permanent residence is outside of our service area.
3. _____ You attempted to enroll outside of an enrollment period.
4. _____ We *didn't get* the information we requested from you within the timeframe listed in our request.

[5. _____ You have drug coverage such as from an employer or union and you told us you don't want to join <PDP name>.]

If <PDP name> paid for any of your prescriptions, we will bill you for the amount we paid.

If item 3 is checked, remember that you can enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. If you meet certain special exceptions, such as if you move out of <PDP name>'s service area, you may enroll in a new plan. Otherwise, you can only enroll in a plan, disenroll from a plan, or switch plans between November 15th and December 31st of each year.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If any of the checked items are wrong, or if you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 7 – PDP Model Notice for CMS Rejection of Enrollment

Referenced in section: 30.4.2

<Date>

Dear <Name of Beneficiary>:

Medicare has denied your enrollment in <PDP name> due to the reason(s) checked below.

1. _____ You have neither Medicare Part A nor Part B.
2. _____ You requested to enroll in a different Plan for the same effective date, which canceled your enrollment with <PDP name>.
3. _____ You attempted to enroll outside of an enrollment period.

If <PDP name> paid for any of your prescriptions, we will bill you for the amount we paid.

If item 3 is checked, remember that you can enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. If you meet certain special exceptions, such as if you move out of <PDP name>'s service area, you may enroll in a new plan. Otherwise, you can only enroll in a plan, disenroll from a plan, or switch plans between November 15th and December 31st of each year.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If any of the checked items are wrong, or if you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 8 - PDP Model Notice to Send Out Disenrollment Form

Referenced in section: 40.1

<Date>

Dear <Member>:

Attached is the <PDP name> disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <PDP name>.

When can I disenroll from <PDP name>?

Medicare will only allow you to disenroll at certain times during the year. After we receive your disenrollment form, <PDP name> will let you know if you can disenroll at this time. If you can disenroll, we will also tell you the effective date of your disenrollment.

Until your disenrollment date, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, <PDP name> may not pay for your prescriptions. After your disenrollment date, <PDP name> won't cover your prescription drugs.

When can I make changes to my Medicare coverage?

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, or you qualify for extra help in paying for your prescription drug costs (see below). If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

When should I submit a disenrollment request?

You **should not** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare *Prescription Drug Plan* or Medicare Advantage-Prescription Drug *Plan*. Enrolling in a prescription drug plan or a Medicare Advantage-Prescription Drug *Plan* will automatically disenroll you from <PDP name>.

You **should** fill out the attached form only if you no longer want Medicare prescription drug coverage and want to disenroll from this coverage completely.

If you would like to disenroll from <PDP name>, please fill out the form, sign it, and send it back to us in the enclosed envelope. You can also fax a signed and dated form to us at <fax number>.

By disenrolling from <PDP name>, you are disenrolling from your Medicare prescription drug coverage. You may have to pay a late enrollment penalty in addition to your premium for Medicare Prescription Drug coverage if you join a Medicare Drug Plan in the future. For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Attachment

Exhibit 9 - PDP Model Disenrollment Form

Referenced in section: 40.1

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your effective date after we *get* this form from you.

Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Member ID:			
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	

By completing this disenrollment request, I agree to the following:

<PDP name> will notify me of my disenrollment date after they *get* this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at <PDP name> network pharmacies to *get coverage*. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for *certain* special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I *don't* have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

Signature* _____ Date: _____

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <PDP name> by Medicare.

If you are the authorized representative, you must provide the following information:

Name : _____
Address: _____
Phone Number: (____) ____ - ____
Relationship to Enrollee _____

Exhibit 10 - PDP Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in section: 40.1.5

<Date>

Dear < Member>:

We received your request to disenroll from <PDP name>. You will be disenrolled starting <effective date>. Therefore, beginning <effective date>, <PDP name> *won't* cover *your* prescription drugs.

Until <effective date>, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, *except in* an emergency, <PDP name> may not pay for your prescriptions.

What should I do now?

If you have already enrolled in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage), you should receive confirmation of your enrollment from your new Plan. If you have not enrolled in another Medicare Plan, you should consider enrolling in one. If you do not enroll in a new plan at this time or you do not have or obtain creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

What if my premium was being deducted from my Social Security benefit check?

If your Medicare Part D premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you have not received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE.

When can I make changes to my Medicare coverage?

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, or you qualify for extra help in paying for your prescription drug costs (see below). If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Where can I get more information?

For information about the Medicare *plans* available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. Thank you.

Exhibit 10a - PDP Notice to Confirm Voluntary Disenrollment Identified Through TRR

Referenced in section: 40.1.5

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> *won't* cover *your* prescription drugs.

What should I do now?

If you have already enrolled in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage), you should *get* confirmation of your enrollment from your new Plan. If you *haven't* enrolled in another Medicare Plan, you should consider enrolling in one. If you *don't* enroll in a new Plan at this time, or you *don't* have or *get* creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

What if my premium was being deducted from my Social Security benefit check?

If your Medicare Part D premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you have not received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE.

When can I make changes to my Medicare coverage?

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, or you qualify for extra help in paying for your prescription drug costs (see below). If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Where can I get more information?

For information about the Medicare *plans* available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you think you *didn't* disenroll from <PDP name> and you want to stay a member of our *plan*, or if you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 10b – PDP Notice to Confirm Disenrollment Identified Through Transaction Reply Report – Reassigned LIS

Referenced in section: 30.1.5 (*E*)

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> *won't* cover *your* prescription drugs. You *got* a blue letter from Medicare in October *explaining* that *Medicare* will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <*PDP name*>.

If you haven't already, you should soon *get a letter from your new plan confirming* your enrollment that will take effect on January 1, <following calendar year>.

You can call this new plan with questions about their coverage, formulary, and pharmacy list.

If you have questions about why Medicare changed your plan or other Medicare *plans* available in your area, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048).

If you have questions about this disenrollment from <PDP name> or you want to remain a member of our *plan*, please call <PDP name> at <toll-free number> <days and hours of operation>, TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 11 - PDP Notice for Part D Plan Denial of Disenrollment

Referenced in section: 40.1.5

<Date>

Dear < Member>:

We recently *got* your request to disenroll from <PDP name>. We cannot accept your request for disenrollment *for the reason checked below*:

1. _____ You attempted to make a change to *<PDP name>* outside of an enrollment period. Medicare limits when and how often you can *make changes to your coverage*.
2. _____ The request was made by someone other than the enrollee and that individual *isn't* the enrollee's authorized representative.
3. _____ *We didn't get the information we requested from you within the timeframe listed in our request.*

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area or you qualify for extra help in paying for your prescription drug costs (see below). If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 12 - PDP Model Notice for CMS Rejection of Disenrollment

Referenced in section: 40.1.5

<Date>

Dear < Member>:

Medicare has denied your disenrollment from <PDP name> because you have attempted to make a change to your *plan* outside of an enrollment period. *Medicare* limits when and how often you can *make changes to your coverage*.

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, or you qualify for extra help with your prescription drug costs (see below). If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you believe this *information is* wrong, or if you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 13 - PDP Model Notice of Disenrollment Due to Death

Referenced in section: 40.2.3

<Date>

To the Estate of < Member> :

Medicare *told* us *about* the death of <Name of Member>. Please accept our condolences.

<Member>'s coverage in <PDP name> ended as of <disenrollment effective date>. If plan premiums were paid for any month after <disenrollment effective date>, we will issue a refund to the Estate within 30 days of this letter.

If the Medicare Part D premium was being deducted from <Name of Member>'s Social Security benefit, please allow up to 3 months for us to process a refund. If the estate has not received a refund from Social Security within 3 months of this letter, a representative of the estate should contact 1-800-MEDICARE.

If this information is wrong, please contact your local Social Security office to have their records corrected. You can call Social Security at 1-800-772-1213 from 7:00 am to 7:00 pm, Monday to Friday. *TTY users should call TTY 1-800-325-0778.* If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY/TDD number>. We are open <days and hours of operation>.

Thank you.

Exhibit 13a - PDP Model Notice for auto-enrollments provided by CMS with recent deceased code

Referenced in section: 30.1.4.*F*.

<Date>

To the Estate of < Member> :

Medicare *told* us *about* the death of <Name of Member>. Please accept our condolences.

We are sending this letter because Medicare had enrolled <Name of Member> in <PDP name>, a plan that provides Medicare prescription drug coverage. Because of this report of death, <Name of Member>'s coverage in <PDP name> ends as of <disenrollment effective date>. *If plan premiums were paid for any month after <disenrollment effective date>, we will issue a refund to the Estate within 30 days of this letter*

If this information is wrong, please contact your local Social Security office to have their records corrected. You can call Social Security at 1-800-772-1213 from 7:00 am to 7:00 pm, Monday to Friday. *TTY users should call 1-800-325-0778*. If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 14 - PDP Model Notice of Disenrollment Due to Loss of Part D Eligibility

Referenced in section: 40.2.2

<Date>

Dear < Member>:

Medicare has told us that you no longer have Medicare <Insert A and/or B as appropriate>. Therefore, your membership in <PDP name> ended on <disenrollment effective date>. If your plan premium was paid for any month after <disenrollment effective date>, we will send you a refund within 30 days of this letter.

If you *haven't* already done so, please contact your local Social Security office to have their records corrected. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY users should call 1-800-325-0778.

If this information is wrong, and you want to stay a member of our plan, please contact us. If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 15 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in section: 50.2.1

<Date>

Dear < Member>:

Medicare *'s records* incorrectly show you as deceased.

If you *haven't* already done so, please go to your local Social Security *office* and ask them to correct your records. After you do this, please send us written proof at <address>. When we *get* this proof, we will tell Medicare to correct their records.

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. *You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below.*

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you for your continued membership in <PDP name>.

Exhibit 16 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Termination

Referenced in section: 50.2.1

<Date>

Dear < Member>:

On <date of request>, you told us that your enrollment in Medicare <insert Part A and/or Part B as appropriate> was ended in error and that you want to stay a member of <PDP name>.

[Sponsors that are able to verify current Medicare entitlement may omit the following:

To do this, please complete the following three steps no later than <insert date: 60 days from date of disenrollment notice>:

1. Contact your local Social Security office and ask them to correct their records. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY users should call 1-800-325-0778.
2. Ask Social Security to give you a letter that says they have corrected your records.
3. Send the letter from Social Security to us at: <address of PDP name> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we *get* this letter, we will tell Medicare to correct its records.]

*[Sponsors that are able to verify current Medicare entitlement insert: **Social Security corrected the error.** We will tell Medicare to correct its records.]*

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions to *get <PDP name>* prescription coverage. *You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below.*

*[Sponsors that are able to verify current Medicare entitlement **may** omit the following:*

If we learn that you *don't* have Medicare <insert Part A and/or Part B as appropriate>, or if we *don't get* proof that you have Medicare by <insert date: 60 days from date of disenrollment notice>, you will have to pay for any prescription drugs you *filled* after <disenrollment date>.]

If you have any questions or need help, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you for your continued membership in < PDP name >.

Exhibit 17 - PDP Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another PDP Organization

Referenced in section: 50.2.2

<Date>

Dear < Member>:

Thank you for letting us know you want to stay a member of <PDP name> after we sent you a letter that said we had disenrolled you from our *plan*.

Based on what you told us, we understand that you cancelled your *request to enroll* in the other Plan and want to stay a member of <PDP name>. Please send us a letter by <30 days from date of disenrollment notice> that says you want to stay a member of <PDP name>. Your letter must also say whether or not you filled any prescriptions at pharmacies outside of <PDP name>'s network since <original effective date of disenrollment>. If you *didn't* fill any prescriptions at pharmacies outside of our network since <original effective date of disenrollment>, we will fix our records after we receive your letter. You can mail your letter to us at <address>. Or you can fax it *to* us at <fax number>.

In the meantime, you should continue using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. *You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below.*

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 18 - PDP Model Notice to Close Out Request for Reinstatement

Referenced in section: 50.2

<Date>

Dear < Beneficiary>:

We cannot process your request to be *reinstated* in <PDP name> because we *haven't gotten* [*select appropriate item for member's situation: <your letter asking for reinstatement, the information we requested>*]. As discussed in our letter dated <date of letter>, you were required to send us this [*select appropriate item for member's situation: <letter, information>*] by <date placed on notice in Exhibit 16 or 17> to remain a member of our *plan*.

You were no longer a member of our plan as of <effective date>. If <PDP name> paid any costs for prescriptions you filled after <effective date>, we will bill you for the amount we paid.

Please remember that if you *don't have* Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's) , you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 19 - PDP Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment

Referenced in section: 40.3.1

<Date>

Dear < Member>:

Our records show that we *haven't gotten* payment for your < PDP name > plan premium as of <date>. If we *don't get* payment by <insert last day of grace period>, we will have to disenroll you from <PDP name>. To avoid disenrollment, you must pay <amount due to avoid disenrollment> by <insert last day of grace period>. If we do not receive your payment by <insert last day of grace period>, we will ask Medicare to disenroll you from <PDP name> beginning <effective date>.

This letter *applies* only to your <PDP name> benefits. Your other Medicare benefits *won't* be affected if you are disenrolled from <PDP name>.

If you don't want to be a member of <PDP name> and don't want any other Medicare drug plan, you may be able to disenroll from <PDP name>. However, Medicare limits when you can make changes to your coverage. You can only enroll in a new plan or disenroll from <PDP name> from November 15 through December 31 each year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, or you qualify for extra help with your prescription drug costs. Also, if you don't have or get other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty for Medicare prescription drug coverage in the future.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you want to disenroll from < PDP name > now, you should do one of the following:

1. Send us a written request at <address>.
2. Call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.. TTY users should call 1-877-486-2048.

If you think we have made a mistake, or if you have any questions, please call < PDP name > at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

<Contract#, Material ID#, CMS approval date (if applicable)>

Exhibit 20 - PDP Notice of Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

Referenced in section: 40.3.1

<Date>

Dear < Member>:

On <date of notification letter>, we mailed you a letter stating that your *plan* premium was overdue. The letter said that if you *didn't pay your premium*, we would disenroll you from < PDP name >. Since we *didn't get* that payment, we have asked Medicare to disenroll you. Your disenrollment from < PDP name > will be effective <effective date>. After <effective date>, < PDP name > *won't* cover *your* prescription drugs.

This letter only *applies* to your <PDP name> benefits. Your other Medicare benefits *aren't* affected by your disenrollment from < PDP name >.

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Medicare limits when you can *make changes to your coverage*. ***From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of < PDP name >'s service area, or you qualify for extra help with your prescription drug costs.***

Please remember, if you *don't* have or *get* other coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 21 - PDP Notice of Failure to Pay Plan Premium - Confirmation of Involuntary Disenrollment

Referenced in section: 40.3.1

<Date>

Dear < Member>:

Medicare has confirmed your disenrollment from < PDP name > *because you didn't pay* your *plan* premium. Your disenrollment begins <effective date>. After <effective date>, < PDP name > *won't* cover *your* prescription drugs.

This letter only *applies* to your *<PDP name>* benefits. Your other Medicare benefits *aren't* affected by your disenrollment from < PDP name >.

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

*Medicare limits when you can make changes to your coverage. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of < PDP name >'s service area, or you qualify for extra help with your prescription drug costs.*

Please remember, if you *don't* have *or get* coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

<Contract#, Material ID#, CMS approval date (if applicable)>

Exhibit 22 - Model Acknowledgement of Request to Cancel Enrollment Request

Referenced in section: 50.1.1

<Date>

Dear < Member>:

As you requested, we have cancelled your *request to* enroll with < PDP name >.

If you were enrolled in another Medicare Prescription Drug Plan or a Medicare Health Plan (such as a Medicare HMO or PPO) before enrolling with < PDP name >, you may appear on their records as being disenrolled. If you want to stay a member of that Plan, you will need to notify them that you enrolled in < PDP name > but have cancelled your enrollment. They may request a copy of this letter for their records.

*Medicare limits when you can make changes to your coverage. **From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year.** Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area *or you qualify for extra help with your prescription drug costs.* **From November 15 through December 31 each year,** you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.*

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

Please remember that if you don't have or get prescription drug coverage that is at least as good as Medicare's (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 23 - Model Acknowledgement of Request to Cancel Disenrollment Letter

Referenced in section: 50.1.2

<Date>

Dear < Member>:

As you requested, we have cancelled your disenrollment with < PDP name >. Thank you for your continued membership in our *plan*.

You should continue to fill your prescriptions at < PDP name > network pharmacies. If you use an out-of-network pharmacy, *except in* an emergency, < PDP name > may not pay for your prescriptions. *You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below.*

If you submitted an enrollment request to another Prescription Drug Plan or a Medicare Advantage Plan, you may appear on their records as being enrolled in their *plan*. Since you have told us you want to stay enrolled in < PDP name >, you will need to contact the other *plan* to ask them to cancel your enrollment before your enrollment takes effect. They may ask you to write them a letter for their records.

Medicare limits when you can make changes to your coverage. From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area or you qualify for extra help with your prescription drug costs. People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 24 - PDP Model Notice to Confirm Auto-Enrollment

Referenced in section: 30.1.4 (*F*)

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <insert member name>

You are getting this letter because Medicare is enrolling you in our <PDP name>, and your coverage begins <effective date>. Medicare is also mailing you a yellow letter about your enrollment. Please keep both letters for your records.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

What are my costs in this plan?

Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- **\$0** per month for your < PDP name > premium,
- \$0 for your yearly prescription drug plan deductible,
- <insert applicable copay levels> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name> at the number below.

What if Medicaid used to pay for my prescription drugs?

Remember, if Medicaid used to pay for your prescription drugs, Medicaid won't continue to cover the drugs it used to. Some state Medicaid programs may cover the few prescriptions that won't be covered under Medicare prescription drug coverage. But even if your state Medicaid program covers a few prescriptions, this coverage alone won't be as good as Medicare's (also referred to as "creditable coverage"). To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

What if I have other prescription drug coverage?

If you now have *or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. You or your dependents could lose your other health or drug coverage completely and not get it back if you join a Medicare drug plan.* Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. *Please* call your insurer or benefits administrator if you have any questions.

What if I want to join another plan or I don't want Medicare prescription drug coverage?

You are not required to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join.

If you don't want Medicare prescription drug coverage *at all*, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 25 - PDP Model Notice to Confirm Facilitated Enrollment

Referenced in section: 30.1.4 (*F*)

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear < member >

You are getting this letter because Medicare is enrolling you in our <PDP name> and your coverage begins <effective date>. Medicare is also mailing you a green letter about your enrollment. If you want coverage to begin earlier, you must tell us by <last day of month that is two months earlier than effective date>.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

What are my costs in this plan?

Because you qualify for extra help with your prescription drug costs, you will pay no more than *the following*:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert copay amount or 15% coinsurance> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please call <PDP name> at the number below.

What if I have other prescription drug coverage?

*If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join a Medicare drug plan.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call you insurer or benefits administrator if you have any questions.*

What if I want to join another plan, or I don't want Medicare prescription drug coverage?

You are not required to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, simply call that plan to find out how to join.

If you don't want Medicare prescription drug coverage *at all*, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 26 - PDP Acknowledgement of Request to Decline or Opt-Out of Part D *Prior to Effective Date*

(Referenced in section 30.1.4 (G))

<Date>

Dear < Member>:

As you requested, < PDP name > has processed your request to decline (opt-out of) Medicare *prescription drug coverage*. Your decision to decline Medicare *prescription drug coverage* doesn't affect your enrollment in Medicare Part A or Part B. *If you previously had drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs.*

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

Our records show that you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help. If you *continue to* qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you change your mind and decide you would like to join, please contact < PDP name > at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or visit www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

Exhibit 26a - PDP Acknowledgement of Request to Disenroll from PDP and Opt-Out of Part D After Effective Date

(Referenced in section 30.1.4 (G))

<Date>

Dear < Member>:

*As you requested, < PDP name > has processed your request to disenroll from (opt-out of) Medicare prescription drug coverage. Your decision to disenroll from Medicare prescription drug coverage doesn't affect your enrollment in Medicare Part A or Part B. Your disenrollment from <PDP name> is effective <effective date>. After this date, < PDP name> will no longer pay for your prescription drugs. **If you previously had drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs.***

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

Our records show that you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help. If you continue to qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you change your mind and decide you would like to remain in our plan, please contact < PDP name > at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or visit www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

Exhibit 27 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region

Referenced in section: 40.2.1.4

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear < Member>:

You recently told us that you live in <state>. To make sure that you have Medicare prescription drug coverage where you live, we are enrolling you in <PDP name> that serves <insert states in the new plan's region>. Your new coverage will begin < effective date>.

If you disagree with the information in this letter or if you have any questions, please call <PDP name> at the phone number provided at the end of this letter.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert applicable copayments> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name>.

You aren't required to be in <PDP name>. If you want to join a different Medicare prescription drug plan, call *that* plan to find out how to join. You can also call 1-800-MEDICARE (1-800-633-4227, which is open 24 hours a day, 7 days a week) or visit www.medicare.gov on the web to choose and join a plan in your area that meets your needs. TTY users should call 1-877-486-2048.

If you have any questions, please call our <Customer Service, Member Services> department at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. Thank you.

Exhibit 28 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor DOES NOT offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region

Referenced in section: 40.2.1.4

<Date>

Dear < Member>:

You recently told us that you live in a place where we *don't* provide *a* Medicare prescription drug plan with premiums fully covered by extra help. You must live in <insert states where current PDP is offered> to be enrolled in <PDP name>. We have asked Medicare to disenroll you from < PDP name > beginning <effective date>.

It is important for you to call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) to choose and join a plan that serves your state or territory. TTY users should call 1-877-486-2048. If you want to learn about other *Medicare prescription drug* plans *in your area that* you can join, call 1-800-MEDICARE or visit www.medicare.gov.

If you disagree with the information in this letter or if you have any questions, please call customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 29 - Model Reassignment Confirmation

Referenced in section: 30.1.5 (*E*)

<Member #>

<RxID>

<RxGroup>

<RxBIN>

<RxPCN>

Dear < member >

You are getting this letter because Medicare has enrolled you in <PDP name> for coverage beginning January 1, <following calendar year>. You should have already received a blue letter from *Medicare* telling you that they were moving you from the drug plan you were originally assigned to because either 1) that plan was leaving the Medicare program on December 31, <current calendar year>, or 2) the cost for that plan was increasing beginning January 1, <following calendar year>.

As of January 1, <following calendar year>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you *use an out-of-network pharmacy, except in an emergency*, <PDP name> may not pay for your prescriptions.

[*Optional*: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

Because you qualify for extra help with your prescription drug costs, you will pay no more than *the following*:

- \$0 per month for your < PDP name > premium,
- *<insert applicable deductible>* for your yearly prescription drug plan deductible,
- <insert applicable LIS copay/coinsurance amount that will be charged in following calendar year> when you fill a prescription.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact customer service.

You aren't required to be in <PDP name>. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join. If you don't want Medicare prescription drug coverage *at all*, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open [<days/times> of operation and, if different, <TTY hours of operation>]. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 30 - Optional Notice for “Losing Plan” to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC)

Referenced in section: 30.1.5 (*E*)

Dear < Member>:

Recently *Medicare sent you a blue letter* telling you that they will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <*PDP name*>.

The letter also said that you can stay in <*PDP name*> in <following calendar year>. However, if you stay *with us*, you will pay a higher monthly premium in <following calendar year>. If you want more information to help you decide, please call our <PDP name> <days and hours of operation>, at <customer service toll-free number>. TTY users should call <TTY number> for the hearing impaired. We will send you more information about *the following*:

- **How your monthly premium would change for <following calendar year>**
- **How your benefits and costs would change for <following calendar year>**
- **What to do if your drug in <following calendar year> is no longer on the formulary or is more expensive**

If you would like this information to help you decide or if you want to stay in <current plan>, call and let us know as soon as possible.

You can also get information about the Medicare Program and Medicare drug plans by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, seven days a week, to answer questions about Medicare.

If you do nothing, your membership with us will end on December 31, <current calendar year>. You will get information from your new plan telling you about your benefits and any costs for <following calendar year>.

If you have any questions, please call customer service at <toll-free number><days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 31 - Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes

[Member #]

<Date>

Dear < Member>:

Your enrollment in <**PDP name**> has been updated.

[Insert one or more of the following, including sufficient detail, to describe the specific enrollment change:

- You have been enrolled in <**PDP name**>. Your coverage will start on <start date> and will end on <end date>. *[Insert information about premiums, if applicable, and how to access coverage, etc.]*.
- Your enrollment in <old **PBP name**> has been changed to <new **PBP name**>. Your coverage in <new **PBP name**> will start on <date>. *[Insert information on premium differences (if any), cost sharing information, and other details the individual will need to ensure past and future coverage is accessible and clear]*.
- Your enrollment in <**PDP name**> started on an earlier date. Your coverage will start <date>. *[Include information about premiums and coverage here]*
- Your enrollment in <**PDP name**> has been changed to start on a later date. Your coverage with <**PDP name**> will start on < date>. *[Insert information about refunding premium, where applicable, and impact to paid claims]*
- Your enrollment in <**PDP name**> ended on < date>. This means you won't have coverage from <**PDP name**> after <date>. *[Insert appropriate descriptive information, such as premium owed if the date has moved forward, or premium refunds if the date has moved back, and impact on paid claims or how to submit claims, as applicable]*.
- Your enrollment in <**PDP name**> has been cancelled. This means that you don't have coverage from <**PDP name**>. *[Insert information about refund of premium, if applicable, and impact to any paid claims]*.
- *[Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary.]*

Call <PDP name> at <toll-free number> <days and hours of operation> *if you have any questions or want* more information. TTY users should call <toll-free TTY number>.

Did you know that people with limited incomes may qualify for extra help to pay for their Medicare prescription drug costs? If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Thank you.

<Contract#, Material ID#, CMS approval date (if applicable)>

Exhibit 32 - Model Employer/Union Sponsored Prescription Drug Plan Group Enrollment Mechanism Notice

<Date>

Dear (name)

<Name of Employer or Union> is enrolling you in <name of PDP> as your retiree prescription drug plan beginning <effective date>, unless you tell us *by <insert date no less than 21 days from the date of notice> that* you don't want to join our plan.

What do I need to know as a member of <PDP name>?

This mailing includes important information about <PDP name> and the coverage it offers, including a summary of benefits document. Please review this information carefully. If you want to be enrolled in this Medicare *prescription drug plan*, you don't have to do anything, and your *coverage will start* on <effective date>.

Once you are a member of <PDP name>, you have the right to appeal plan decisions about payment or services if you disagree. Read the <insert either Member Handbook or Evidence of Coverage document> from <PDP name> when you get it to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

<PDP Name> is a Medicare drug plan and is in addition to your coverage under Medicare Part A or Part B. Your enrollment in <PDP name> doesn't affect your coverage under Medicare Part A or Part B. It is your responsibility to inform <PDP name> of any prescription drug coverage that you have or may get in the future. You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, your enrollment in <PDP name> will end that enrollment. Enrollment in <PDP plan> is generally for the entire year.

By joining this Medicare prescription drug plan, you acknowledge that <PDP Name> will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <PDP Name> will release your information, including your prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

What happens if I don't join <PDP name>?

You aren't required to be enrolled in this plan. <insert information about other group sponsored plan options, if there are any>. You can also decide to join a different Medicare drug plan. *You can* call 1-800-MEDICARE (1-800-633-4227) *24 hours per day, 7 days per week* for help in learning how. *TTY uses should call 1-877-486-2048.* However, if you decide not to be enrolled <insert consequences for opting out of group plan, like that you cannot return, or that other benefits are impacted>.

What should I do if I don't want to join <PDP name>?

To request not to be enrolled by this process <insert clear instruction for opting out, including telephone numbers and days/hours of operation>.

What if I want to leave <PDP name>?

Medicare limits when you can make changes to your coverage. You may leave this plan only at certain times of the year or under certain special circumstances. To request to leave, call <PDP name> or call 1-800-MEDICARE. <PDP name> serves a specific area. If you move out of the area that <PDP Name> serves, you need to notify us so you can disenroll and find a new plan in your area.

Keep in mind that if you leave our plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

If you have any questions, please call customer service at ,toll-free number><days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 33: PDP Model Notice to Research Potential Out of Area Status

Referenced in section 20.2.1.3

<Date>

<Member ID>

Dear <member name>:

We have recently received information that your address may have changed and that you may not live inside the service area of <plan name>. **If you don't contact us to verify your address, you will be disenrolled from <plan name> effective <disenrollment effective date>.**

It is important that you contact us to verify your permanent address. You may use this form and return it to us in the enclosed envelop or you may call our <Customer Service, Member Services> department at <phone number><days and hours of operation>. TTY users should call <TTY number>.

Please note that your permanent address must be inside our service area in order for you to be a member of <plan name>. You may request that we send mail to you at another address outside of our service area. You may also temporarily reside for up to six months outside our service area and remain a member of <plan name>. But if you permanently move outside our service area or if you temporarily live outside our service area for more than six months in a row, we must disenroll you from <plan name>. You will have an opportunity to enroll in a plan that serves the area where you now live.

Your Permanent Address

Please tell us the permanent address where you live. Don't use a post office box.

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____

Your Temporary Address

If you are currently living somewhere other than your permanent address, please provide the address. Don't use a post office box. (You may skip this section if you are living at your permanent address.)

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____
When did you begin living at this address? _____
When do you expect to return to your permanent address? _____

Your Mailing Address

If the address that you want us to use to send information to you is different than your permanent address, please provide it below. (You may skip this section if your mailing address is the same as your permanent address that you provided.)

Street or P.O. Box: _____

City, State, ZIP: _____

County: _____

Current Phone Number: _____

If you have moved and haven't told the Social Security Administration (SSA) about your new address, you may call them at 1-800-772-1213 (TTY 1-800-325-0778) Monday-Friday, 7am to 7pm.

If you have any questions or need help, please call us at the <Customer Service, Member Services> phone number listed above.

Thank you.

Exhibit 34: PDP Model Notice for Disenrollment Due Out of Area Status (No Response to Request for Address Verification)

Referenced in section: 40.2.1.3

<Date>

<Member ID>

Dear <member name>:

On <date of notice requesting address verification> we asked you to contact us so that we could determine whether you had moved out of the [Optional: <Parent Organization Name>] <plan name> service area. As we explained in our earlier letter, in order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to six consecutive months.

Our records show that you haven't responded to our earlier letter. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.** Beginning <effective date>, <plan name> won't cover your prescription drugs.

This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >.

What if I disagree with this decision?

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?

You may have up to two months to join a new Medicare Prescription Drug Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

If you don't enroll in a Medicare Prescription Drug Plan during this special two-month period, you may have to wait to enroll in a new plan. Medicare limits when you can enroll in a new Medicare Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO).

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. You may not enroll in a new Plan during other times of the year unless you meet certain special exceptions.

What happens if I don't enroll in another Medicare Prescription Drug Plan?

Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What should I do if I've moved?

If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?

If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 35 – PDP Notice of Disenrollment Due to Out of Area Status (Upon New Address Verification from Member)

Referenced in section: 40.2.1.3

<Date>

<Member ID>

Dear <member name>:

Thank you for informing us of your recent change of permanent address. Your permanent address is now outside the <plan name> service area. In order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to six consecutive months. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>**. Beginning <effective date>, <plan name> won't cover your prescription drugs.

This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits aren't affected by your disenrollment from <PDP name>.

What if I disagree with this decision?

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?

You may have up to two months to join a new Medicare Prescription Drug Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don't enroll in a new plan right now?

If you don't enroll in a Medicare Prescription Drug Plan during this special two-month period, you may have to wait to enroll in a new plan. Medicare limits when you can enroll in a new Medicare Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO). ***From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. You may not enroll in a new Plan during other times of the year unless you meet certain special exceptions.***

What happens if I don't enroll in another Medicare Prescription Drug Plan?

Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

What if my premium was being deducted from my Social Security benefit check?

If your Medicare Part D premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What should I do if I've moved?

If you have moved and have not notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?

If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.